CAPTA: SUCCESSES AND FAILURES AT PREVENTING CHILD ABUSE AND NEGLECT

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, AUGUST 2, 2001

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AT PREVENTING CHILD ABUSE AND NEGLECT

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Thursday, August 2, 2001

U.S. House of Representatives,

Subcommittee on Select Education,

Committee on Education and the Workforce,

Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:09 a.m., in Room 2175, Rayburn House Office Building, Hon. Peter Hoekstra presiding.

Present: Representatives Hoekstra, Greenwood, Schaffer, Platts, Roemer, Scott, Holt, and McCollum.

Staff present: Pam Davidson, Professional Staff Member; Patrick Lyden, Professional Staff Member; Michael Reynard, Deputy Press Secretary; Whitney Rhoades, Legislative Assistant; Deborah L. Samantar, Committee Clerk/Intern Coordinator; Ruth Friedman, Minority Legislative Associate/Education; Cheryl Johnson, Minority Counsel/Education and Oversight; Maggie McDow, Minority Legislative Associate/Education; and Joe Novotny, Minority Staff Assistant/Education.

Chairman Hoekstra. A quorum being present, the Subcommittee on Select Education will come to order.

We are meeting today to hear testimony on CAPTA, and the successes and failures of preventing child abuse and neglect. Under Committee Rule 12-B, opening statements are limited to the Chairman and the Ranking Minority Member of the Subcommittee. Therefore, if other members have statements, they may be included in the

hearing record.

With that, I ask unanimous consent for the hearing record to remain open 14 days, to allow members' statements and other extraneous material referenced during the hearing to be submitted in the official hearing record.

Without objection, so ordered.

OPENING STATEMENT OF CHAIRMAN PETE HOEKSTRA, SUBCOMMITTEE ON SELECT EDUCATION, COMMITTEE ON EDUCATON AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

I am pleased to welcome our guests here today, our guests, witnesses, and members, to the Select Education Subcommittee hearing on ``CAPTA: Successes and Failures at Preventing Child Abuse and Neglect." As many of you know, one of our Subcommittee's responsibilities during this year is to reauthorize the Child Abuse Prevention and Treatment Act. CAPTA established a focal point with the Federal Government to identify and address issues of child abuse and neglect, and to support effective methods of prevention and treatment.

CAPTA was last authorized in 1996, with significant changes. However, little is known as to how or if these changes are working to improve the prevention and treatment of child abuse and neglect. Today's hearing is designed to provide an overview of how CAPTA has been implemented and administered since the last reauthorization, and to specifically look at what has worked and not worked in the prevention of child abuse and neglect. The Subcommittee is also interested in hearing some suggestions as to how we can improve CAPTA during this upcoming reauthorization.

Our witnesses today are expected to share with us their expert knowledge of child abuse and neglect issues; the indicators and trends on the condition of children in the U.S.; how CAPTA has helped or hurt prevention efforts; and just provide us with an overall view of where we are today in the fight against child abuse.

According to recent statistics, almost 3 million reports of possible child maltreatment were made to child welfare agencies. Approximately 60 percent of these reports were investigated, and 826,000 children were estimated to have been victims of child abuse or neglect in 1999. Of these victims, 58 percent suffered neglect, 21 percent suffered physical abuse, and 11 percent were sexually abused.

While the overall number represents a continuation of a downward trend since 1993, the long-term trend in child abuse reporting has been one of substantial growth, with the number of maltreatment reports more than quadrupling since 1976. However, it

should be noted that increased reporting does not necessarily mean an equivalent increase in actual abuse or neglect. In fact, the proportion of child maltreatment reports that are substantiated has grown smaller over time.

I do understand that some believe this number is actually higher, since there are numerous cases that go undetected and reported. Despite progress in promoting child abuse awareness, and the endless efforts made to prevent child abuse and neglect, much work remains.

This morning, we are fortunate to have a distinguished panel of witnesses, and I wish to thank each of you for taking the time to be with us. In just a few moments, I will proceed with introductions, but when we return from the vote, I will yield to the gentleman from Indiana, Mr. Roemer, the Ranking Member, for his opening statement.

I think the best course of action at this point is for the Subcommittee to break, vote and see what is going on the floor, and we will come back after the vote, or the multiple votes. What's that?

Mr. Schaffer. I said, ``Make yourselves comfortable."

Chairman Hoekstra. Make yourselves comfortable. We are not sure exactly what we are in for today. But you will get used to this over time; we have. So we will be back as soon as we are done voting. All right, thank you.

WRITTEN OPENING STATEMENT OF CHAIRMAN PETE HOEKSTRA, SUBCOMMITTEE ON SELECT EDUCATION, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C. – SEE APPENDIX A

[Recess.]

Chairman Hoekstra. All right, we are back, and I think we are going to have at least a relative period of calm, so we can move forward with the hearing.

I would now like to yield to the distinguished Ranking Minority Member of the Subcommittee, Mr. Roemer, for his opening statement. Mr. Roemer?

STATEMENT OF RANKING MEMBER TIM ROEMER, SUBCOMMITTEE ON SELECT EDUCATION, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

Mr. Roemer. Thank you, Mr. Chairman. Nice to have Assistant Secretary Horn before us once again. And I appreciate the opportunity, with you and Mr. Greenwood, to hold this hearing this morning. Again, I want to congratulate you and Mr. Greenwood, and Mr. Scott, and others for the bipartisan work that we achieved yesterday on the juvenile justice bill.

And certainly the task before us this morning is one where bipartisanship and research and resources and follow-up to welfare reform is certainly needed, and certainly desired by many of us. I am looking forward to hearing from today's witnesses about what we can do to improve our child welfare system, and how we can prevent children from ever entering this system in the first place.

We often hear about children like Brianna last year here in Washington, D.C., who so tragically slipped through the cracks. However, many children are helped by overburdened caseworkers. I am looking forward to hearing about how we can help caseworkers and States more effectively serve our most vulnerable children in our country.

I think that research is a critical component to this effort. It helps us identify best practices, and ways to more effectively spend our tax dollars. I was disappointed to see that President Bush's budget cut funding for research and demonstration projects by $16 million.

Though we continue to try to improve our method and efforts to decrease child maltreatment, we still have much ground to cover. CAPTA plays a critical role in placing resources into prevention and treatment of child abuse. It is important that we continue to work to find more effective ways to help prevent this abuse, and also to treat these children and these families.

At this point, Mr. Chairman, I would love to hear from the witnesses, and I appreciate the opportunity to sit here and learn from a good panel. Thank you very much.

Chairman Hoekstra. Good, thank you. The first panel will consist of one person, the Honorable Wade Horn. Dr. Horn was recently confirmed as Assistant Secretary for Children and Families at the U.S. Department of Health and Human Services. This is his fourth day on the job, so we are pleased that you are well prepared and schooled in the material that we will be talking about today.

Dr. Horn previously served as the president of the National Fatherhood Initiative. Also, from 1989 to 1993, Dr. Horn was the Commissioner for Children, Youth, and Families, and the chief of the Children's Bureau within the U.S. Department of Health and Human Services. He has authored numerous articles pertaining to children and family issues and has frequently been featured on television and radio as a child development expert.

Welcome. Welcome back to the executive branch. And we are looking forward to working with you on this legislation. And we will yield to the Assistant Secretary. Welcome.

STATEMENT OF THE HONORABLE WADE F. HORN, ASSISTANT SECRETARY FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. Horn. Thank you very much, Mr. Chairman. It is a pleasure to be back here.

Mr. Chairman and distinguished members of the Subcommittee, I want to thank you for the opportunity to testify on reauthorization of several programs critical to the well-being and safety of our nation's children: the Child Abuse Prevention and Treatment Act, known as CAPTA; the Adoption Opportunities Act; and the Abandoned Infants Assistance Act. I greatly appreciate the leadership demonstrated by the members of this Subcommittee in protecting children from abuse, neglect, or abandonment, and in promoting adoption.

As presented in the President's 2002 budget, we believe the 1996 reauthorization of these programs established a strong framework for the critical services they provide, and that major changes to the legislation are not necessary. While we support this current statutory structure, we also believe more progress needs to be made in preventing child abuse and neglect. Although the rate of children who are victims of substantiated abuse and neglect has been decreasing over the past several years, it is also true that in 1999 State and local child protective services agencies reported approximately 826,000 substantiated cases of child abuse and neglect. Clearly, more needs to be done.

Therefore, along with reauthorization of these critical programs, and in recognition of the fact that a broad spectrum of response is needed, the President's 2002 budget includes four additional proposals addressing this critical need.

First, a $200 million increase in the Promoting Safe and Stable Families program, so that States can provide more preventative services to families in crisis. Second, a new $67 million program to provide funding for mentoring children of prisoners, and to support positive family reunification. Third, a new $64 million program to invest in

strengthening fatherhood and marriage. And finally, a new $33 million program to support maternity group homes, ensuring that young mothers who are unable to live with their own families because of abuse or neglect can have access to safe and stable environments, where advice on parenting skills is provided.

As a clinical child psychologist, I can attest to the fact that when we focus on strengthening the family and parenting skills, we have a better chance of reducing the incidence of child abuse and neglect, and ensuring that every child grows up in a loving and committed family.

Now I would like to discuss each of the programs briefly being considered for reauthorization by the Subcommittee.

The Child Abuse Prevention and Treatment Act, in combination with other federal child welfare statutes, plays an important role in our nation's efforts to protect children from abuse and neglect. Under the framework of a federal-state child welfare system, CAPTA provides funding for: one, a basic state grant program; two, a community-based family resource and support program; three, the Children's Justice Act grants to States; four, the National Child Abuse and Neglect Data System, known as NCANDS; five, research and demonstration projects; and finally, a national clearinghouse on child abuse and neglect information.

The 1996 reauthorization made two significant changes to CAPTA. First, it streamlined the basic state grant program by replacing the annual application with a five-year plan that encourages comprehensive planning, while also requiring that each State establish a citizen review panel to examine CPS agency policies and evaluate their effectiveness in protecting children.

Second, the reauthorization consolidated several programs under the Community-Based Family Resource and Support program, in order to support the development and expansion of State networks of community-based, prevention-focused family resource and support programs. Although these family support programs are beginning to report positive outcomes, more will be learned over the next several years as data from longer-term studies become available.

The Children's Justice Act provides grants to States to improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect, especially those involving child sexual abuse or exploitation. States have been creative in using these funds to support innovative approaches to reducing the negative impact of child abuse and neglect.

NCANDS provides much of our knowledge about the number and characteristics of cases of child abuse and neglect. And that data is currently being used in a variety of departmental initiatives, most notably the Department's new outcome-focused system for monitoring State child protection and child welfare systems or programs, known as the Child and Family Services Reviews.

Finally, the National Clearinghouse on Child Abuse and Neglect Information supports all of these efforts by organizing and disseminating information on all aspects of child maltreatment, in order to build capacity of professionals in the field.

Two other programs are also being reauthorized this year: the Adoption Opportunities Program and the Abandoned Infants Assistance Act. Again, we support reauthorization of both these programs, and look forward to working with the committee in doing that.

And finally, in conclusion I would add that addressing the needs of our nation's most vulnerable children and families requires national leadership, comprehensive and coordinated efforts at the State and federal level, and compassionate, caring responses from community-based organizations.

I look forward to working with the Congress, and particularly this Subcommittee, in reauthorizing these three key programs, and funding the President's new initiatives, so that we may further our efforts to ensure that every child grows up in a safe and stable family.

I would be pleased to answer any questions you might have.

WRITTEN STATEMENT OF THE HONORABLE WADE F. HORN, ASSISTANT SECRETARY FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Hoekstra. Thank you. Some of the most troubling issues that come up in this area are the proper balance between the role of the government and the role of parents. Are you aware of whether the Department has done research in that area, and whether the Administration at this point in time believes that the balance between protecting the child and protecting the rights of parents, whether the current legal framework provides the proper balance?

Mr. Horn. As a child psychologist and someone who has worked directly and indirectly with the child protective services system, and as someone who is also a parent of two children, I know that there needs to be a delicate balance between ensuring that the government and State agencies have the authority to intervene to help children who are being abused or neglected, yet at the same time protecting the rights of the parent, and recognizing the parents' right to direct the upbringing of their children.

We think that within the context of CAPTA, that balance is adequate. Does that mean that in every instance that balance at the ground level is adequate? No. Do we need to do more, in terms of training and technical assistance, to ensure that that balance is in fact respected? I think that we do. But in the context of CAPTA reauthorization, I think that the balance, from a legislative perspective, is appropriate.

Chairman Hoekstra. Then what the Administration is saying is that really, as we take a look at this, other than perhaps the President's new initiatives, the rest of the authorizing legislation really just needs some minor tweaking?

Mr. Horn. That is our view. There may be some technical amendments that may be necessary. But we view CAPTA, as reauthorized in 1996, and the changes that were given to CAPTA at that time, do in fact give a good structure and an adequate structure for helping to improve the child welfare system in that context.

But I think it is important to keep in mind that there is a broader system, and other initiatives that can also be helpful in this regard, and I have identified some of those in my testimony.

Chairman Hoekstra. Okay, great. Thank you very much. Mr. Roemer?

Mr. Roemer. Mr. Secretary, nice to have you before the Subcommittee.

It seems to me that we need to make some significant improvements in our welfare system. And in order to serve these children and help them more, we need to find out what kinds of methods and what kinds of programs can better serve these children. And it seems to me that research is a way to go for this, to do the research, to share the best practices, and to help disseminate those to other States.

Consequently, I am a little bit mystified, I guess, as to why the Administration would propose to reduce the child abuse-related research and demonstration programs by $16 million. Can you help me with that?

Mr. Horn. Well, I agree with you, Congressman, that research and demonstration projects are important in this area. There is a lot we need to learn, a lot we don't know. And research and demonstration projects can be very helpful in generating a new knowledge base, which also needs to be aggressively disseminated to States and community-based organizations that are involved in this arena.

The $16 million reduction that you note is a reduction in one-time earmarks that were inserted by the Congress in the last appropriations. And it was as a matter of policy from the Administration, there was an across-the-board elimination of one-time earmarks across all budgetary authorities.

But at the same time, I would point out that we did increase the Safe and Stable Families program by $200 million, and within that context we hope to spur additional work in this area. There also, I am very committed to the idea that we not only provide money for demonstration programs, but that we also insist that demonstration programs be evaluated rigorously. And so we think there is adequate existing authority to be able to push forward an evaluation and research agenda within the broader framework of the budget.

Mr. Roemer. Well, let me say from a personal perspective that I don't mind, in fact, I encourage you to do the rigorous review, and the competition, and the peer review and so forth on these kinds of demonstration programs. I don't even mind, from a personal perspective, if you try to make sure that Members of Congress don't pick out, earmarking the project.

What I do have trouble with, though, is when we are trying to help some of the most vulnerable children in our society with research and best practices, and follow through, now we are receiving reports, with this economic downturn, that there are more families out there with children that are homeless, that are in trouble. And we know that they are going to be experiencing a host of different welfare-related program problems. And this relates directly to the kind of problems that we are going to see, that we are trying to prevent in the first place from happening.

So I would hope that if you are going to cut the program, that you find ways to correct the program rather than cut the money from the program.

With that in mind, my last question would be, how do we continue to try to put more money on the prevention side, in the early stages of this, rather than addressing the problem?

Mr. Horn. Well, as I mentioned, I think that if you look at the broader context of the President's budget, you see a commitment to expanding work that I think is directly related to the prevention of child abuse and neglect. I have mentioned the $200 million increase in the Safe and Stable Families Act. I have also mentioned the $67 million proposal for working with children of incarcerated parents, as well as the $64 million new initiative for working with fathers to improve their parenting skills.

And as a child psychologist who has worked extensively in the area of parenting education, I can tell you that I believe firmly that one of the ways we can most effectively reduce child abuse and neglect is by helping on the front end, by helping parents develop the skills necessary to be good, nurturing, involved parents with their kids.

And we also have asked for a $33 million new initiative for maternity group homes, so that mothers who can't be living at home, because of abuse, neglect, or other kinds of issues, are provided with a safe, supportive environment, and with, also, the parenting education and information that they need so that we can prevent child abuse from happening in the first place.

So I do believe that this budget has a commitment to expanding, in a creative way, ways of getting information about improving parenting skills to parents that need them in order to advance a mutual agenda that we all share, which is to reduce the unacceptably high rate of child abuse and neglect.

Mr. Roemer. Well, I know you have experience in the Fatherhood Initiative. I would certainly hope that you bring that experience and those best practices, and those resources, to this Department. Thank you.

Chairman Hoekstra. Mr. Greenwood?

Mr. Greenwood. Thank you, Mr. Chairman. And welcome. Good morning.

I first want to comment a little bit about Mr. Hoekstra's concern about the balance of families and government on this. And I bring to this question my experience. I met my wife when we were both child welfare caseworkers back in our home of Bucks County. And what we found, and I don't know that much has changed, was that the caseload was so heavy that it seemed that we could only work on the cases where the abuse and the neglect were so severe that the question of, you know, are we too intrusive, was really not much of a factor; that in the cases where it was marginal, they sort of got pushed off because we had so many severe cases to deal with. Which isn't of course to argue that there haven't been plenty of cases where the balance has been skewed.

One of the realities is that I was not a parent when I was a caseworker. And I did not bring that perspective in, and I think a lot of the caseworkers, if you look out in the field, are young people in their twenties who don't have the perspective of parenthood. And I think, as hard as it would be to swallow this, that if you want to fix that problem, you have to pay these caseworkers family-supporting wages.

If you wanted to have the ideal caseworker, who brings the skills to the job and the perspective of being a parent, then you are going to have to pay them enough to raise a family on, so that they can be in this work and still bring that balance.

When I left that work and went to the legislature, I formed a Children's Caucus, and I spent a lot of time, a dozen years in the State legislature, trying to find ways to prevent child abuse. And when I looked for the place that I thought would be most critical to intervene, I looked at women who came to hospitals, frequently without any prenatal care, to deliver. And these women were crack abusers, alcoholics, heroin addicts, and so forth. And the predictability that that child, after the Medicaid system spent hundreds of thousands of dollars, maybe, to bring the child into good health, and then discharge the mother and child, the predictability that that child was not going to fare very well was pretty high.

And I tried to pass legislation that would say when a child was born in a hospital with neonatal abstinence syndrome, the presence of a controlled substance, the mother was an alcoholic, fetal alcohol syndrome, that that would in and of itself require the intervention of a caseworker at the hospital. The health care providers would be mandated to report this, and that a caseworker would have to be brought in, to make a safe plan of care. Didn't say the child was ipso facto dependent, but would say, let's see. Where do you live, mother? Are you living in a car? Are you living in an abandoned house? Do you have resources? You obviously have a substance abuse problem; are you willing to get treatment for that?

It seemed to be a great, great opportunity to prevent abuse and neglect. I never could pass that. I always could pass it in the Republican-controlled House, but never in the Democratically-controlled Senate or vice versa, because there were questions about, you know, is this anti-women because you were picking on the women, not the men, in this situation? Was it somehow racist because of a disproportionate amount of minorities involved in substance abuse? And so forth.

And that always was a source of great frustration to me, because I thought, I don't care what color the kid is. Let's intervene when the kid is in this obviously precarious position.

I would be interested in your comments on that, whether you think there is more that we could do to intervene at that moment, to help the mother, and the newborn, and the rest of the family if there is one.

Mr. Horn. Well, it is clear that you bring a lot of personal and very important expertise to this issue. I also, early in my career, worked as a homemaker, when I interned with Child Protective Services in southern Illinois when I was in graduate school. And some of my experiences are the same as what you have just spoken about.

It is clear that there are moments when parents are hungry for information. It is also clear that we don't always take advantage of those moments. And one of those moments when parents are hungry for information is when a child has just been born, or

just before a child is born. And I think that we need to do a better job of working with those parents at those moments, when they are hungry for the kinds of information that we know can be helpful in reducing the probability of that parent abusing or neglecting that child.

And so I would be very interested in furthering conversation with you about that. Because I do think that if we intervene at those times, we will have less tragic cases, where kids are showing up already abused or neglected later on.

And I think what we need to do is understand that there are a variety of moments when we can do that kind of intervention. One is what you describe, but there certainly are others. In my work with fathers, it is clear that men also are interested in information at that period of time. And we have to do a better job of reaching out to them and giving them those kinds of parenting skills that will lessen their probability of getting into situations where a child winds up abused or neglected.

And so I would be very happy to work with you on those issues.

Mr. Greenwood. And in fact, if there is a father involved at that moment, that opportunity is an opportunity to reach the father as well, because if you need to make a safe plan of care for the child in the weeks following birth, you would want the father, obviously, to be brought into that process.

Mr. Horn. Absolutely.

Mr. Greenwood. My time has expired. Thank you very much. Thank you, Mr. Chairman.

Chairman Hoekstra. Thank you. Ms. McCollum?

Ms. McCollum. Thank you, Mr. Chair. I am going to, in the interests of time, focus on mental health and recovery from chemical dependency. And by that, I also include the biggest problem in this country, which is alcoholism.

What specifically does this Administration have in plan for people who suffer from chemical dependency and mental health? I served on the Board of Crisis Nursery in Ramsey County, and when the economy was bad, when welfare reform was going on, people who either had a chemical dependency problem, maybe were in a recovery stage, would be challenged at that point because of stress. People who were hanging on day-to-day with mental illness, that sometimes was just enough to kind of push the depression or something over.

We have seen a rise in St. Paul, Minneapolis, as other parts of the country have, with families with mental illness, not only harming themselves but harming their children. What is in this proposal that addresses what we know to be a huge problem? And many of the individuals that we have been discussing today do not have access to health insurance, or if they do, they do not cover chemical dependency or mental health. What is in this proposal to help those families, and literally save the lives of those children?

Mr. Horn. You are quite correct that one of the primary drivers of child abuse and neglect is substance abuse. And far too often, we act as if there is this system for this problem and that system for another problem, and a third system for a third problem.

And Secretary Thompson is very committed to what he calls the One Department Initiative at HHS. He is very committed to driving better coordination between the various operating divisions, and the programs contained therein, so that we can better address people holistically. And so one of the things that I am very interested in doing is ensuring that there is better coordination between those programs that deal with substance abuse, substance abuse prevention and intervention found within HHS, with those programs that I oversee that have to do with child welfare and welfare services in general, and particularly child abuse and neglect.

So I think that part of the answer to your question is that Secretary Thompson has shown extraordinary leadership in saying to this department that we are going to do a better job of coordinating across programs, rather than assuming that if you have got a program, you have got a constituency, you don't have to worry about anything else. Well, in far too many cases, it is the same client. And so what we have to do is coordinate those programs better than we have in the past.

Ms. McCollum. Sir, I would be appreciative to know just what the Federal Government's role has been in chemical dependency treatment in those instances, and mental health counseling, and where the gap is. Because I think we are going to find, as former Governor Thompson, who was from my neighboring State, we have done the same thing in Minnesota, you find that there are huge gaps there.

And where the gaps are, if we are serious about this, we are going to have to address those. So if you could share through the Chair and myself what our shortcomings are going to be in this area, in coordinating not only with the Federal Government, but coordinating with States, counties, non-profits, crisis nursery boards. Because if we don't really address the root cause of the problem, which I am hearing you passionately say you want to do, but if we don't do that, then we are coming in too late.

And I really appreciate, Mr. Chair, the opportunity to be at this Committee meeting for a while. I look forward to reading the other members' testimony. And this is really important; I am very pleased to be a part of this Subcommittee.

Chairman Hoekstra. Thank you. This is a very important issue, and I am glad to see we have got interest on the Committee to work through the reauthorization of this, and to work with the Administration and others to make sure we put together a good reauthorization bill. Mr. Schaffer?

Mr. Schaffer. Thank you, Mr. Chairman. I have just got maybe one question. I was in the State legislature for nine years, and carried two pieces of legislation to overhaul our child protective services laws in our State. It tends to be kind of a radioactive issue, as you know, and that was certainly true in our case.

But through that whole process, I was persuaded on a couple of occasions that, at least at the time, there were some grants that were awarded by the Federal Government that were caseload-driven, where the caseload became a factor in the funding formula to States. Could you comment on that, to the extent that that might be still true today? And, if it is not, then that question is over.

Mr. Horn. Well, I don't believe that that is the case within CAPTA. I think the programs in CAPTA are population-driven, not caseload-driven. That is more of an issue within another aspects of the child welfare system; for example, in Title IV-E, foster care, clearly that is a caseload-driven reimbursement system.

But in terms of the CAPTA programs, it is my understanding they are population-driven, not caseload-driven. So that shouldn't be a problem, at least not within the current structure of CAPTA.

Mr. Schaffer. Well, that answers my question. Thank you Mr. Chairman, I yield back.

Chairman Hoekstra. All right. Thank you for being here. We look forward to working with you. I am sure we will see you again.

Mr. Horn. Hopefully not any more this week, though. Two hearings are enough.

Chairman Hoekstra. Yeah, okay, we will agree with that as well. Thank you.

With that, I would also like to then invite the second panel forward.

Let me introduce the second panel. We have Dr. Richard Gelles. Dr. Gelles holds the Joanne and Raymond Welsh Chair of Child Welfare and Family Violence in the School of Social Work at the University of Pennsylvania. His expertise is in child welfare and domestic violence; he is co-director of the Center for Children's Policy, Practice, and Research at the University of Pennsylvania, as well as co-director of the Center for the Study of Youth Policy. That is a mouthful to get on one business card. Welcome, Dr. Gelles.

We have Mr. Patrick Fagan. Mr. Fagan is presently the Senior Policy Analyst for Family and Culture at the Heritage Foundation. Previously he worked at the Free Congress Foundation, on the staff of Senator Dan Coates of Indiana, and at the U.S. Department of Health and Human Services in the first Bush Administration as Deputy Assistant Secretary for Family and Community Policy. Mr. Fagan, welcome to you.

We also have Mr. Charles Wilson. Mr. Wilson is the Director of the Center for Child Protection at the Children's Hospital and Health Center in San Diego, California. The Center for Child Protection provides therapy to hundreds of victims of child abuse and family violence and their families, delivers family support services, and designs and delivers various training and professional education programs. Formerly, Mr. Wilson was the Executive Director of the National Children's Advocacy Center in Huntsville, Alabama, and was the Director of Family Services at the Tennessee Department of Human Services. Mr. Wilson, welcome to you.

And then we have Ms. Deborah Strong. Ms. Strong is the Executive Director of the Michigan Children's Trust Fund, the Michigan chapter of Prevent Child Abuse America. The Children's Trust Fund is an independent non-profit organization dedicated to the prevention of child abuse and neglect. Previously she was a consultant and program administrator of Family Support Services for the Michigan Department of Social Services. Ms. Strong has served in the Michigan office of Children and Youth Services,

and on the governor's Children's Cabinet Council. Welcome to you.

Dr. Gelles, we will begin with you.

STATEMENT OF RICHARD J. GELLES, JOANNE AND RAYMOND WELSH CHAIR OF CHILD WELFARE AND FAMILY VIOLENCE, SCHOOL OF SOCIAL WORK, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

Mr. Gelles. Thank you, Mr. Chairman. It is an honor to be invited to testify today. And I think back to the early 1970s, when I attended the initial hearings that led to the authorization of the Child Abuse Prevention and Treatment Act. And I have had on previous occasions the opportunity to testify regarding this reauthorization.

CAPTA in many ways is a small and minor piece of federal legislation. The funding that CAPTA authorizes on a comparative basis is rather modest. And yet CAPTA has always been considered the centerpiece of federal legislation regarding child abuse and neglect. The definitions included in CAPTA have served as a template, defining what acts of omission and commission warrant reporting to State child protective service agencies. And while funding for research and demonstration projects is decidedly modest, the projects and issues specified by Congress and CAPTA have established the knowledge-seeking and knowledge-building agenda for researchers and practitioners.

One of the major successes of CAPTA has always been that it has helped elevate the tragedy of maltreatment from a private trouble to a social issue, and ultimately to a social problem. We have been quite successful in generating public concern and establishing a child protective service system that is larger, broader, and better trained than it was 30 years ago.

Thirty years ago, child protective service records were often recorded on index cards. Many child protective service workers had high school educations. And the knowledge base that workers drew upon was often laden with myths and misconception. At the initial hearings on CAPTA, witnesses could not even agree as to the magnitude of the problem, its causes, its consequences, or what should be done to address the problem.

Nonetheless, the successes that have grown out of CAPTA have been limited. The successes notwithstanding, our child welfare system in the United States is in deep trouble. These troubles are not merely local. They are not failings of an individual caseworker, a supervisor, and an administrator. When tragedies occur at the local level, the mantra-like claim is the child ``fell through the cracks'' in the system. These are not small cracks; they are national fault lines. They are long, they are deep, and they are always on the verge of swallowing up more victims.

Nearly nine years ago, the National Commission on Children reported that if the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system. At present, at least 27 States, including many of the home States of members of this Committee, are under court order to improve child welfare services. Between 1,500 and 2,000 children are killed by their caretakers each year; half of these children are slain after they or their families have come to the attention of child welfare authorities.

On any given day, as many as 600,000 children reside in some form of out-of-home care, and from the data that have been derived from the authorization of CAPTA, we know that a disturbingly large portion of these children have spent more than 36 months in out-of-home care, with very little possibility or probability that they will have a permanency placement. Thus, each year approximately 20,000 to 25,000 children age out of the system. Congress addressed that last year with the Independent Living Act.

When a tragedy occurs at the local level, or a crisis hits, political leaders, agency administrators, and advocates have a tendency to want to round up the usual suspects. In the case of the child welfare system, the usual suspects tend to be more money, more staff, more training, or blaming the judges, or blaming the laws.

I am not going to speak specifically about the provisions of CAPTA, but rather take the typical academic's broad view. And I think the time has come for new solutions. Swinging the pendulum from child safety to family preservation, from parents' rights to government intrusion, is not going to be the solution. Spending more money, hiring more staff, more training, has not been the solution for 30 years. Replacing treatment programs such as Homebuilders with family group conferencing is unlikely to succeed. Child welfare reform can only be achieved by identifying the true weaknesses of the system and applying out-of-the-box thinking to the problem solving.

One of the true and longest-lasting weaknesses of the system is this child welfare system is only as strong as its weakest link, and the weakest link tends to be at the individual worker level. I would have to argue, and since I don't represent schools of social work, that our schools of social work nationally bear much of responsibility for the dearth of professionally trained front-line child welfare workers.

Even if child welfare workers are adequately trained, and prepared to undertake this work, they often go about their business and open up a toolbox that provides only limited tools. One thing I want to point out, and I don't know whether one of my colleagues will speak to it, but the need for an evidence-based approach to child welfare interventions.

I see my time is up. I want to bring simply four issues to the fore. One, I would hope that the Committee would consider whether CAPTA's definitions of child abuse and neglect are too broad; whether mandatory reporting is working; we have taken it on faith for 30 years that it works. There has never been an empirical investigation of its strengths and weaknesses.

Are there technologies available that can aid the child welfare system in assessing reports, conducting assessments, and monitoring children at work? And lastly, are the provisions of CAPTA consistent with the Adoption and Safe Families Act of 1997? Thank you.

WRITTEN STATEMENT OF DR. RICHARD J. GELLES, JOANNE AND RAYMOND WELSH CHAIR OF CHILD WELFARE AND FAMILY VIOLENCE SCHOOL OF SOCIAL WORK, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA – SEE APPENDIX C

Chairman Hoekstra. Thank you very much.

Mr. Fagan?

STATEMENT OF PATRICK FAGAN, WILLIAM H.G. FITZGERALD RESEARCH FELLOW, FAMILY AND CULTURAL ISSUES, HERITAGE FOUNDATION, WASHINGTON, D.C.

Mr. Fagan. Thank you very much, Mr. Chairman. It is an honor to be here. Thank you very much for calling me to testify. I want to address a very broad issue, and then a couple of smaller issues that I think are, narrower, not smaller, issues related to CAPTA.

As the honorable Wade Horn mentioned, there is a need, I think, to move forward to begin to address, let me call it the social infrastructure of child abuse, in which, actually, the Federal Government plays a large role that it probably is not aware; that it is, in my judgment, a culprit in forming part of the culture of, essentially the culture of abuse.

Let me give some broad statistics first. America has become a very dangerous place for a child to come into existence. All children. One-third of American children are aborted before they are born. Of those who are born, one-third will be born out of wedlock, where mom and dad are not in agreement together to take care of the child. And then of those who are born into married families, 40 percent will see their parents divorce before they reach age 18. What that means is that out of every 100 children conceived in the United States, only 27 will reach age 18 with both their parents taking care of them. Back in 1950, that number was totally different. Out of every 100 children born, only 12 saw their parents split or abandon them before age 18.

We have put in place, actually, a culture where the vast majority of American parents cannot stand each other enough to take care of their children until they reach adulthood. That is the broad culture. We have in America, as far as children are concerned, a culture of alienation. These are frightening figures, rarely brought, but I think that is the broad infrastructure underneath, then, what rises to the surface and becomes, at a statistical level, the very tough cases of real abuse and neglect, which the system is then designed to address.

So, to reduce and change this culture that feeds, we have to work to rebuild a culture of marriage, of stability and security within the family. The Federal Government's role is particularly important in welfare, which is also up for reauthorization this coming year. The regulations in welfare payments and in the EITC are such that they massively penalize marriage among the poor. And as a result, the vast majority of poor don't get married, because it is very much in their economic disinterest to get married. That is part of a broad social infrastructure.

Moving to a different set of issues, again, that will possibly come to rest on this system, on CAPTA, not this year, not even probably this next couple of years, but possibly four or five years out, at the international and the national level in child advocacy issues, there is a growing hostility towards the role of parents in family. You can see it in the United Nations, and in the Convention on the Rights of the Child; the role of the parent is massively pushed to the side. This convention has been signed by President Clinton; it has not been brought to the Senate for ratification, so it still does not hold sway. But should it, I have listed a number of issues that would become a key part of the child protection system which are totally outside of our national and our cultural way of looking at the role of parents.

The right to privacy for the child in all aspects of their life within the family. The right to professional counseling without parental consent. The full right to abortion, contraceptives, even for children as young as ten years of age, without parental consent. There is a list of issues that are a threat.

Let me then address an issue that is, I think, something that CAPTA should address. There is a practice of permitting anonymous tips, reporting of potential child abuse. And I think that practice is good, but that total anonymity is not. That the anonymity of the reporter be protected from potentially abusing adults makes a lot of sense. But the anonymity being there even for the caseworker and the investigators

makes absolutely no sense.

And if you look at the data that is now coming in, the overworked caseload aspect that Congressman Greenwood was addressing, overwhelmingly those anonymous tips lead to a very, very low rate of substantiated abuse. Where the highest substantiation comes from is from professionals and people who are well known. This occasionally is a source of malicious reporting, and there is no redress, not even in the two States that have laws that can penalize malicious reports, because the anonymity protects the maliciousness. I think that should be addressed in CAPTA.

Likewise, due process, at the moment of investigation, I think should apply to parents. The Fourth Amendment applies to them, just as much as it does to people who are murderers or potential murderers, or thieves, or any of the rest. This, there are many, many complaints, and I would suggest that you call us, maybe in future hearings, or at least get testimony from those who specialize in this area, because what is happening is that among parents who are; particularly the whole home-schooling group of parents in this country; the reputation of the child protective services has actually become very low, and they are very suspicious of it. That is not good for public confidence, and addressing the due process issue will begin to address that.

The last point: we have an absolute need that the National Incidence Survey; the National Incidence 1, 2, and 3 were done in the '80s and up to the early '90s. We have had no National Incidence Survey in the last decade. There is a need to do that. And within that, I would suggest that we gather the data that will show and illustrate where, from a family structure point of view, the abuse is really taking place.

We know from Great Britain data; we have no American data; none at all that is reputable, or that anybody can put any weight behind. But from Great Britain, we know that the rate of abuse is 33 times higher for convicted serious abuse, 73 times higher for fatal child abuse, when you compare the intact married family, which has the lowest, with the condition most linked, which is the mother cohabiting with a boyfriend, where you get 33 for serious abuse, 73 times higher for fatal abuse. These are the infrastructure issues that have to be addressed, and research is going to play a key role on that broad aspect, just as much on the best practices, which is then critical for the actual therapeutic intervention.

Thank you very much.

WRITTEN STATEMENT OF MR. PATRICK FAGAN, WILLIAM H.G. FITZGERALD RESEARCH FELLOW, FAMILY AND CULTURAL ISSUES, HERITAGE FOUNDATION, WASHINGTON, D.C. – SEE APPENDIX D

Chairman Hoekstra. Thank you.

Mr. Wilson?

STATEMENT OF CHARLES WILSON, DIRECTOR, CENTER FOR CHILD PROTECTION, CHILDREN'S HOSPITAL AND HEALTH CENTER, SAN DIEGO, CALIFORNIA

Mr. Wilson. Thank you. I, too, would like to express my appreciation for the invitation. I have worked in this field since 1972 and spoken before several State legislators, but this is my first opportunity to come before this body.

And I come to this today from the perspective of someone who has been on the front line as a child protective service worker, who has supervised workers, who has managed State systems. And part of what drew me to Children's Hospital in San Diego was the fairly unique mix of a national orientation of trying to do something about child abuse while we worked day-to-day with children who have actually experienced it. In our hospital today, there are young children who are clinging to life, who have suffered from the effects of this. And I am able, still, in this role, to put a face on the realities of abuse and neglect, and keep me kind of centered as to why I have chosen to do this for almost 30 years.

The National Child Abuse Coalition, who I represent today, brings together the perspectives of a variety of organizations that share a common interest in stopping the pain of children. And that group has worked for over a year, examining CAPTA, looking at directions in which we believe it can be enhanced.

The bottom line is we believe there is an opportunity here for this Congress and for the Federal Government to exert a leadership role, which heretofore has not been assumed, in part, as my colleague Dr. Gelles said, because CAPTA, in the final analysis, is a small and minor piece of legislation. It is, and should be, the centerpiece of the federal response to child abuse and neglect. This is where the leadership can emerge from.

The policy framework in CAPTA has a number of strengths. You have done a good job of putting some real good direction for State agencies and for community agencies. But we all know that the child welfare system is full of challenges and problems and frustrations, and we have a long, long way to go.

If the Federal Government is going to exert a leadership role in basically stopping child abuse and neglect; preventing it, reducing it, drastically reducing the prevalence of it over the next 20 years; then that leadership role is going to need to be exerted by a piece of legislation that addresses the issue of abuse and neglect. And CAPTA is the best vehicle to carry that forward.

Right now, the Federal Government's role is disproportionately balanced and focused on the back end of the problem, once children are in care. The amount of resources going to pay for board and care, for adoption services, are not inappropriate. But only about 17 percent of the federal response, and the State response, when you put it together, is going to the front end of the system, or protecting children, or preventing child abuse and neglect in the first place.

Towards that end, the Coalition recommends in the written testimony you have before you that we focus on three areas in CAPTA. One is the child protection infrastructure. Now, the child protection infrastructure doesn't necessarily translate into the status quo infrastructure. It doesn't mean more of the same. It means we need to provide an infrastructure for the child protection system of this nation, and that we propose that CAPTA address that through an authorization level of $500 million.

That would move the capacity to make a difference with States far greater than we are able to do today. With the current level of appropriations, most States view the resources they get from CAPTA as money that they can do a project here and a project there, they can experiment. But it really doesn't drive their system. It is not a major funding source. And for CAPTA to be the centerpiece, it is going to have to carry the resources that get the attention of State agencies and provide them with the resources they need to basically try to move the system forward, and advance them in new directions.

We also recognize that CAPTA should be the principal means by which we advance the issue of community prevention. Prevention needs to begin in those early years, working with families, working with young people before, even, they give birth. The notion of providing services to try and prevent child abuse and neglect in the first place has a growing amount of merit.

When I was a director of child welfare, I was always struggling with the issue. How do I put resources into prevention, when I have children in great need right now? I have fires to fight; I don't have the resources to shift off, to try and prevent something that I can't target effectively.

Well, the research that has emerged over the last 10, 15 years, is giving us some guidance about how we can target resources in ways that do in fact reduce the prevalence of child abuse and neglect. And we need to take advantage of that knowledge now and ensure that children who are in families in crisis get the resources they need on the front end, before the abuse and neglect occurs, before the system comes in, before the families are struggling with the intrusion of a State agency.

And we need to focus on research. In 1977, when I was in graduate school, over that summer, I literally read everything written in the English language on child abuse and neglect. It was possible in 1977. The knowledge base that we talk about here is infantile. It has just begun, in the last 15, 20, and 30 years, to build into a literature base on which we can make reasonable judgments. There is much more research today, but we have a long, long way to go. And investing in research and demonstration innovation is clearly a wise, wise investment for this body. And so the National Child Abuse Coalition would recommend the authorization level for research and demonstration be

raised to $100 million, and that we invest seriously.

Part of what drew Children's Hospital and Health Center in San Diego to this problem several years ago was the recognition on the part of our CEO and president. He was basically reviewing some statistics for an annual report, when he recognized that 3 percent of the children who come into the trauma program at Children's Hospital are there because of child abuse or neglect. But 30 percent of the children who die in our hospital from trauma are dying at the hands of their caregivers.

And that shook him quite a bit, and he began to look at the issue. The amount of investment we have made in public health issues; in fighting polio, in fighting cancer, in fighting heart disease; pales, or the resources for child abuse pale in comparison to anything that has been provided to other major public health issues. And if we are going to tackle this issue effectively, we are going to have to invest in it, in trying to understand the phenomena and trying to understand the most effective means to break the cycle.

And if we do so, we have reason to believe that our society will reap many benefits that go far beyond just the issue of this child and this family. In the last few years in San Diego, Dr. Vincent Politti has been researching the patients in one of the large HMOs, with over 40,000 adults who are working, employed adults, and found that he was able to clearly demonstrate; although he didn't set out to do this; that he can link death in their 50s and 60s from cancer and heart disease back to early victimization, because they found that these young people, when they were abused, started engaging in self-medicating types of behavior; smoking, drinking, early sexual activity; which then led later to serious health problems in their lives.

So we see the dynamics of abuse playing out in many, many ways. So the investment, we believe, will make good, sound judgment on the part of this Congress.

Thank you.

WRITTEN STATEMENT OF MR. CHARLES WILSON, DIRECTOR, CENTER FOR CHILD PROTECTION, CHILDREN'S HOSPITAL AND HEALTH CENTER, SAN DIEGO, CALIFORNIA – SEE APPENDIX E

Chairman Hoekstra. Thank you.

Ms. Strong?

STATEMENT OF DEBORAH STRONG, EXECUTIVE DIRECTOR, PREVENT CHILD ABUSE MICHIGAN, ON BEHALF OF PREVENT CHILD ABUSE AMERICA, CHICAGO, ILLINOIS

Ms. Strong. Thank you, Chairman. Good morning, Chairman Hoekstra, Congressman Roemer, and members of the House Education and Workforce Subcommittee.

Thank you for holding this hearing on the reauthorization of CAPTA. I would like to add a special thanks to you, Mr. Chairman, for your work back home in Michigan on behalf of children, and for your leadership in reauthorizing CAPTA. In addition, I would like to extend a special thanks to you, Congressman Roemer, for inviting Prevent Child Abuse America to testify this morning.

My name, as you well know, is Deborah Strong, and in your introduction you talked about the fact that I represent the Michigan Children's Trust Fund, which is Prevent Child Abuse Michigan. The work that we do, and the way that we do it, is done through public awareness, education training, and technical assistance. But mostly, we fund a statewide network of community-based prevention programs. We are also the designated State lead agency for the Community-Based Family Resource and Support program, or Title II, of CAPTA. And with the support of CAPTA, this past year we were able to make a difference in the lives, very positively, of more than 750,000 children and families.

Because I have about ten pages to condense into five minutes, I will be skipping some of this. But part of what you have is a fuller explanation of some of these things. But I would like to also say that I am truly honored to be able to speak on behalf of Prevent Child Abuse America, the leading national organization working at the local, State, and national levels to prevent child abuse and neglect of our nation's children.

For nearly 30 years, Prevent Child Abuse America has worn this leadership mantle. And they do this not only because of their work at the national level, but working with 39 chapters in 38 States and the District of Columbia. We represent a vast network of children and families, family support workers, volunteers, both public and private. And all of us are dedicated to preventing child abuse. And these programs that we offer are voluntary.

I am also honored here to try to highlight some of the great work that is going on in communities across the nation. In our response to this whole issue of child abuse and neglect, I will not try to frame the issue, because I think all of my colleagues before me have done that, and I think you did in your opening remarks, Chairman Hoekstra, did the same. So I will skip those sections that make reference to that, and basically say that we

know that this issue is devastating. It is having long-lasting impact.

But despite the epidemic proportions in the number of children who are reported abused or neglected each year, funding for prevention programs has failed to keep pace with the scope of the problem. As a result, our nation is forced to continually increase spending on the devastating consequences of child maltreatment, when we really do know that some things do work.

Such costs to individual children and families in our nation as a whole are unconscionable, particularly when they can be prevented. Even more devastating is that these costs to society will continue as long as prevention programs remain grossly overlooked and under funded.

CAPTA also enables communities to coordinate and support local networks of prevention services. But even a model program with wonderfully trained staff can fail if parents are unaware of its existence, or how to access it, or the lack of transportation is a

barrier. Service coordination, referrals, outreach are not there. Or, until we begin to develop a critical mass of prevention services throughout the States, we will never be able to truly have a significant impact on this issue in this nation.

To quote President Bush in his proclamation designating April as Child Abuse Prevention Month: ``Prevention remains the best defense for our children. State Community-Based Family Resource and Support programs sponsor activities promoting public awareness about child abuse and prevention."

Prevention is a strong investment in our economy. In April, Prevent Child Abuse America released a landmark study, which looked at the cost our country incurs every year as a direct or indirect result of child abuse. We discovered that today, and every day this year, child abuse and neglect will cost the American taxpayer $250 million, which is more than $94 billion annually. To put it another way, the consequences of child abuse and neglect cost every American family more than $1,400 a year. But families pay only the equivalent of about $1.06 for programs that prevent abuse.

Primary prevention programs; that is, programs that prevent abuse before it occurs; are funded at only $32.8 million, as compared to at least $6 billion for intervention, treatment, and out-of-home placement. There is a tremendous imbalance here. And this does not mean to imply that the costs for treatment and intervention are too high, or that the services themselves should not be provided, because they should be. But it says that we need to do something, that prevention means more than out-of-home placement. It means stopping it before it even occurs.

But, since my time has run out, let me move to a couple other points that I really think are critical. I think that by supporting language in the reauthorization of CAPTA that targets child abuse and neglect prevention, and preserves it as a separate funding stream for primary prevention, the Subcommittee on Select Education will enable communities to fulfill their vital role in providing services and supports to the thousands

of children and families who seek local responses to support themselves in their own communities. And I even have examples that maybe you can ask me about in the question part, about some wonderful things that are happening in Michigan, like the Healthy Family Oakland program, which has some wonderful results.

But I think, to move to what we are asking, we are asking your support, asking you to look at how you can help us shore up families and communities. We are also asking you three-fold questions here, or requests.

One, we request your consideration and support of Title II, Community-Based Family Resources and Support language, that will put forward the National Child Abuse Coalition position, which focuses on core community-based child abuse and neglect prevention programs.

Two, we request that you urge your colleagues on the House Appropriations Committee to increase fiscal year 2002 funding for Title II to its current fully authorized level of $66 million.

And three, we urge you to set a higher authorization level for CAPTA Title II at $500 million. This is so important, I think, if we are going to make a difference in the lives of children.

Thank you.

WRITTEN STATEMENT OF MS. DEBORAH STRONG, EXECUTIVE DIRECTOR, PREVENT CHILD ABUSE MICHIGAN, ON BEHALF OF PREVENT CHILD ABUSE AMERICA, CHICAGO, ILLINOIS – SEE APPENDIX F

Chairman Hoekstra. Thank you very much to the panel. A number of you have brought up the point that we need more funding. I mean, is that, you know, one of the top priorities, just saying, we need more money, and if you get us more money now, that we could make a much bigger impact at the local level?

Ms. Strong. Yes.

Chairman Hoekstra. We have got one yes.

Mr. Wilson. Two yeses.

Chairman Hoekstra. Mr. Fagan? Make sure you put on the microphone, too. Thank you.

Mr. Fagan. Sorry. I would like to suggest something very different. I am not saying money isn't needed; obviously, when you have got a huge

problem, you need huge resources.

But there is a repeated pattern over the years in all of the critiques of this, and it doesn't apply just to child abuse. Dr. Gelles focused on the actual practice at the practitioner level. There are so many different problems that are interfaced into child abuse: you have got addiction, you can have father out of work, you can have out-of-wedlock births, and you have got the abuse of the mother. You can just go on and on. You will find them all interlinked.

The lack of practice of coordination among the professionals treating all these different problems; what you have is a centrifugal force at the professional level, where a doctor will treat this, a caseworker will do this, a school counselor will do this. I remember, because I was in clinical work for years before I switched into public policy, in all of these systems I often felt as a professional that if I was on a receiving end of 10 or 12, sometimes, but even three or four professionals, pulling me in totally different, uncoordinated directions, I would be mentally ill.

The system is crazy. There is no way that funding more and more into these disparate, uncoordinated systems is going to help where all of the professionals have got to be coming together. The fault lies much more in the professional practice than it does in the lack of resources. To me, that is the one huge thing I would require. And I don't know how you can require that.

The Congresswoman from St. Paul was asking for, you know, the mental health issue. The mental health practitioners, and all the professional practitioners, are the crazy ones, if I can say that, by not coming together to help those who are so stressed. They add more to the stress by having the disparate systems not coordinated.

I have said enough.

Chairman Hoekstra. Yes, thank you. Dr. Gelles, and then Mr. Wilson, we will come to you.

Mr. Gelles. I am not unhappy that my colleagues ask for additional money, but I would advise Congress that it probably wouldn't make an enormous difference if it were spent in the exact same way it has been spent for the last 30 years. And what I would predict would happen is in five years you will be asked for $1 billion.

Mr. Greenwood brought up his experience as a caseworker. Many communities have done an enormous amount of work in bringing down the caseloads from 60 families or children per worker down to 15. Children still have horrible things happen to them and die under the watch of the child welfare system when the caseloads are as low as six.

It depends on how you spend the money. It is not how much money you spend. And I would argue that one of the problems with CAPTA is the money has not been spent in a way that it would be most effective. CAPTA requires a lot of money to be spent at the front end, such that the service most families get as a result of CAPTA

funding is an investigation.

I will take issue with Dr. Horn. I think that Safe and Stable Families has the potential of being effective. But not if the money is spent as it has been spent in the past, on intensive family preservation services, which the National Academy of Sciences found not to be terribly effective. However, if the money is spent on Healthy Families, a prevention program which has solid demonstrable evidence found by the National Academy of Sciences, it is a much better investment of federal money, and a much better way of trying to bring about a reduction in child abuse before it occurs.

Chairman Hoekstra. Mr. Wilson?

Mr. Wilson. I think the position that we are advancing is, yes, it does take more resources. But I will also agree that I don't think anyone in the Child Abuse Coalition is suggesting that we spend it the way it was spent in the past.

Mr. Fagan makes a very valid point. And I think that is the essence, as you read through the written testimony that we offer. The answer isn't in funding the public child protection system, and getting it what it needs to be. This is a community responsibility. It is going to take a network of community agencies working collaboratively together. The answer doesn't rest with one discipline or one org.

So to the extent to which CAPTA can advance an agenda which is a multi-disciplinary, community-based agenda which says, we are all going to come together to address this problem and work hand in hand, we can make a much more effective use of those resources.

My years, first in Tennessee and then in Huntsville, and now in San Diego, have convinced me that the issue is bringing the disciplines together and sitting around a table and figuring out what are we going to do together? Yesterday in San Diego, I chaired a meeting that had 20 different professionals representing probably 14 different agencies and disciplines, who sat and discussed case by case, how are we going to reach out to this child and family and make them safe, and help this family heal?

That is the only way you can do it. If the CPS worker, no matter what their caseload is in their office, in isolation, they are not going to have the benefit of that judgment, of those community resources. And families will be pulled apart.

CAPTA can make that leadership. CAPTA can carry this forward. But it does take the resources that are proposed to provide the States with the ability to create those types of community networks.

Chairman Hoekstra. Ms. Strong?

Ms. Strong. Thank you. I, too, you know, agree with some of the things that Mr. Fagan has said. But I also disagree in several other areas, in the sense that while I recognize that the service delivery system is very fragmented in many places, I also recognize that there is a lot of work going on in States right now to remedy that, with coordinated community planning. I also recognize that in my own State, we have what we call multi-purpose collaborative bodies at the local level, which are looking at the resources that are there for families.

But as we begin to look at this piece, overwhelmingly, you know, the point that I would like to make, I view prevention as the last frontier on the service delivery continuum. While we have all those other programs at the table, or we try to coordinate those things, we don't have a lot of prevention programs there.

In addition to this piece, what I find is a problem with the whole prevention piece is that we do need more dollars. We need more dollars for research; we need more dollars to be able to take a program to scale.

I have got the Healthy Family program that I asked you about, in Oakland County, did a five-year longitudinal study. Now, we didn't pay for that. They went to a private funder, a foundation, who was able to help them document the efficacy of their work. And I would like to leave you with two pieces, actually, three.

One of the things that they found out in this program is that those families; it had a controlled study that was attached to it, and it was five-year longitudinal. But of the 322 families that went through this program, only 1.6 percent of these families ended up having a substantiated case of child abuse, versus 14 percent for the control group.

And another factor about this program is that although they were doing wonderful work, they could never take the program to scale. They could never reach all of the families who had a need. And we are talking about a voluntary program where people were coming forth and basically saying, I would like this service.

And a third; I would call it a wonderful unintentional benefit of this piece; was that they discovered that there was a huge cost savings, in terms of emergency room use. These families that were involved in these programs were getting well baby care; they had regular check-ups. They were utilizing their physicians before the condition got exacerbated to something bigger than that. And so a very positive spin off from this was that there was a health care savings.

And so I would like really to say, yes, there is a need for more money. And until we look at this like the medical community has looked at this whole issue of prevention; you know, if medicine hadn't done that, we would still be looking at the next best, latest version of the iron lung. And right now, polio would be ravaging our society.

I think we need to begin to step up to the plate for prevention and do the same.

Chairman Hoekstra. Thank you. Mr. Roemer?

Mr. Roemer. Thank you, Mr. Chairman. I want to again thank the panel for their time and their helpful testimony, and their recommendations as well, too, on the reauthorization of CAPTA.

You have spent some time talking about money, about training for caseworkers, about putting more in the front end of prevention. Tell me specifically some prevention programs that work, in Michigan or in San Diego, and why we should fund them at higher levels, and how we can replicate those kinds of things in Indiana.

Ms. Strong, why don't you start?

Ms. Strong. Okay, let me start. From this whole notion of what works, I think we have a lot of promising and emerging, wonderful things that are going on in communities. I think the thing that we don't have is the dollars to invest in the thing that would prove it to you and others who are funders. And so we all are patching together resources to do the evaluation, or the empirical kinds of studies that you would appreciate.

But there are programs, and there are families; and I felt grossly inadequate coming here today, trying to represent the feel in families. Because there is a qualitative aspect to these programs and services, too, that is hard to quantify. But there is good work being done out of Harvard around this piece.

So what I say to you about this; we know that home visiting programs with certain critical elements and other kinds of supports work. We know that families don't all come to the table with the same knowledge base about how to parent and how to support their children. We also know that there are lots of things that have to do with coordination outreach that CAPTA Title II allows us to do.

So those pieces are critical. I think we can give you more data later, and I can do that.

Mr. Roemer. That would be very helpful, because I want to provide more resources, and I will fight for more resources for this kind of program. But I want to know what kinds of programs work. What can be replicated from the local level in Ann Arbor, Michigan, to the local level in South Bend, Indiana? And how you can invest that money in prevention, which I have heard from everybody that that makes a lot of sense to do on the front end.

But I need to hear the specific programs.

Ms. Strong. Well, I just gave you one, the Oakland County program. We have more Oakland County-type programs throughout the State. But I will put together, through PCAA, some additional testimony that will document some of the good works that are going on nationally.

Mr. Roemer. Thank you. Mr. Wilson? Dr. Gelles? Do you have some recommendations there? Or, I know you spent some of your testimony talking about not only prevention and new programs, but programs that will help our caseworkers get trained better, so that they can spend more of their time on, you know, working through some of these areas and working on the prevention side.

Mr. Wilson. Let me comment on the prevention side first.

Mr. Roemer. All right.

Mr. Wilson. I think there is an emerging body of research that gives us some guidance in prevention programs. In-home visitation programs seem to hold promise, particularly the nurse home visitor program originally developed in Allegany County, New York, David Owles' model, has 20 years' worth of data to demonstrate the efficacy of that model.

Part of the challenge of that is, certainly in San Diego County, trying to find enough nurses to staff the hospital is challenge enough, let alone put nurses in home visiting roles, and speaking the native languages of the families which we work with. And so the next evolution is how do you, then, cross that line? What is the next variation off that theme that works effectively? Para-professional home visitors have been tested out in many communities, starting off in Hawaii. Again, there is promise there.

I think we know some things that work effectively, but the research isn't over on this. I think we can find ways to continue to evolve the design. And so what I would encourage is that resources to do what we know that works, and resources to invest in making sure that it is the most effective and cost-efficient way to accomplish that same end. In the final analysis, we may find it is really a combination of these things. It may be a combination of some center-based services for children, mixed with home visitation programs for the families.

But again, in terms of specific examples, I think we can provide you with written testimony and some guidance as to the most effective ways that the evidence supports at this point on prevention.

Mr. Roemer. Dr. Gelles?

Mr. Gelles. I would refer staff for a little summer reading on behalf of their members.

Mr. Roemer. My staff?

Mr. Gelles. Your staff.

Mr. Roemer. Well, she is pretty busy on the ESEA conference, but we will put her to work on this, too.

Mr. Gelles. I thought they had all this free time coming up.

Mr. Roemer. Well, it's not true.

Mr. Gelles. But it is not that extensive a reading body. First is to turn to the 1998 publication by the National Academy of Sciences, the book itself deals with assessing family violence interventions. There is a substantial chapter on medical and social service and community interventions with regards to child maltreatment.

But I think the most important chapter in that volume is chapter 3, which provides the standards that people should use in judging whether a program is successful or not. The fact that someone says a program is successful is a whole lot different than whether the program actually is successful.

The second piece of little summer reading is a contracted piece of work done by the Office of Juvenile Justice and Delinquency Prevention that was contracted when Jay Belichick headed that agency. It is called ``Eight Programs that Work.'' It was written by Delbert Elliott of the University of Colorado. And it identified, of all the interventions for youth violence and delinquency, the ones that had a substantial body of evidence behind them. And included in that, and included in the National Academy of Sciences volume, was the home health-visiting program that was devised by David Owles.

And the last is a field trip, probably, to Harrisburg, Pennsylvania, where Clay Yeager, with the Governor's Partnership for the Prevention of Violence has taken the OJJDP volume, ``Eight Programs that Work,'' and has brought it to scale in Pennsylvania, and is only funding at the community level programs for which there is evidence that they will be effective.

So there are three levels of information about this. And in fact, the OJJDP contracted volume is a possible template for CAPTA. And that is, perhaps one of the requested bodies of research would be a volume like the OJJDP volume, that collects all of the information on programs that work, only those that have evidence that meets the normal standards of scientific evidence for programs.

Mr. Roemer. I thank you. And I think you just moved me from summer reading to fall research.

Chairman Hoekstra. We would welcome you to come to Michigan, although my colleague might want us to go to Pennsylvania. Mr. Greenwood?

Mr. Greenwood. Thank you, Mr. Chairman. And I will take that field trip to my home State, and go to Harrisburg.

I would like to pursue a very similar line of questioning that we have been going through, because I think we are sort of homing in on where we need to think. And I want to again rely a little bit on my experiences, although I have been out of this process for twenty-some years now, 20 years, anyway.

But here was the dynamic that I faced, over and over again, and I think it still happens. You get an overnight report of neglect or abuse. The Child Protective Services worker goes out to the home, and in instances where the neglect or abuse is so severe that the Child Protective Services worker is very worried that leaving the child with the parents would threaten the child, you take the children out of the home, and you go get a petition for dependency, and you go to the court, and so forth.

And the ironic thing always, to me, was that no matter how abused or neglected these children were, when you separated them they screamed and cried and didn't want to be away from mommy and/or daddy. And the parents were feeling terrible and they were crying. And there you are, dragging these kids apart, taking them off to a judge. And then you put the kid in a foster home.

So you put the child or children in the foster home, and unless the case is really severe, you are not going to ultimately terminate parental rights and go to adoption. You are going to work for reunification. So you say, okay, mom and dad, you have got to get off the juice or the drugs, or you have got to get a job, or get a better place to live. And if you are real lucky, you are spending a lot of money now. Now you are paying daily foster care rates.

Child and parent are separated by miles. Maybe they get to see each other once a week or every two weeks for a visitation. If you are lucky, you can get the kid some therapy through Medicaid. If you are really lucky, you can get some family therapy and bring them together once a week for an hour.

But the thing that always frustrated me was, I am going to work towards reunifying this family. I am scared to death about whether it is the right thing for these kids to do or not. More times than not, I felt like I erred on the side of putting these people back together again, and the kids didn't turn out so well in the long run.

But I always thought, what I need is a little village here where I could bring Mom and Dad, you know, bring the family in, and have the kids and have the social workers all there, and the parent educators and so forth. So instead of this little hour a week here, or

maybe every two weeks you see somebody for an hour, and try to make us all integrate, as if you have actually significantly improved this family, when you are only playing at the margins, I always thought I needed some way to bring the family and the kids in the same place for regular living.

And we tried this with the legislation, the permanency planning legislation, where you had intensive case work and you would get the caseworker in there. But that is a very few number of cases.

So that is the sort of out of the box thinking that I am looking for, and I wonder if you could comment on generally how we get around this sort of difficulty. The preventative side is one thing, but I am talking about where there has been abuse and neglect, how do you really find the model to put the time in to get these parents so that they are really able to parent, and not turn their frustration and their stress into abuse and neglect?

Mr. Gelles. I actually covered a piece of that on pages 8, 9, and 10 of my written testimony. Decision-making at the hotline, decision-making by the caseworkers, decision- making by the judge, are the key cornerstones of an effective child welfare system.

Things haven't changed much in 20 years. Caseworkers are still wrestling with those decisions and not knowing what to do, and are making what I call olfactory risk assessments. A lot of what they do is based on what the house smells like.

Mr. Greenwood. True.

Mr. Gelles. That is not going to lead to good decision-making. Caseworkers need to understand that some families can be changed, some families can't. They need to match the intervention to what the family can take and accept and use. And some decisions are going to have to be made under the timelines of ASFA, that you are just not going to have enough time to change the family, given the child's developmental interests.

CAPTA in its 30-year iteration has not done a particularly good job at spurring research and development around these decision-making issues. The private sector is doing a better job, I think. I have been working with IBM for the past year and a half, developing new technologies for risk assessment, almost such that a caseworker now would be able to go out with a Palm Pilot and have access to-

Mr. Greenwood. Let me, I am sorry to interrupt you, the time is going to run out here. But what I am trying to focus on is, invariably, you know, abusive, neglectful parents over here; child over here, the twain doesn't meet very, very often.

And the caseworker is left with the notion, the question, of when am I going to reunite them, and what is going to be different six months or eight months later, when I reunite them? And what have my intervention strategies been? And when could I ever, for any length of period and length of time, observe them in their natural habitat, so I could work with them there, instead of the sort of artificial visits in the office, or visits in the therapist's office?

Mr. Gelles. Well, one question is why are you going to reunite them? Sometimes that is the more critical question.

Part of the problem has to do with agencies not giving their workers proper directions. In Delaware, the agency wants everything, including apple pie and a Chevrolet. And they don't tell the workers what they are supposed to do. In New York City, Nick Scoppetta, having had to deal with a 26-year-old lawsuit, finally sat down and wrote a mission statement for his agency saying, look, whenever there is ambiguity, you are going to have to err on the side of the well-being, safety, and health of a child, which means you are going to have to close down intervention if there is any ambiguity in your mind, because that is in the child's best interest for permanence.

A lot of these problems have to be sorted out with the agency having a tangible vision. I suspect that the agency you worked for told you had to do everything, didn't tell you what to do when the situation was ambiguous, and then blamed you if there was a mistake. And that is not the proper way to run a child welfare agency.

Mr. Greenwood. Anyone else to comment?

Mr. Wilson. I think the issue you are struggling with is something that every child welfare worker does. A child is at risk. The family that is struggling is bringing a lifetime's worth of experiences there. The fact that you knocked on their door doesn't change their experiences.

You may in fact be a motivating factor, to make them face up to some issues. And in fact, when we looked at some of our most successful cases in Tennessee; we asked where are the best workers, and asked the best workers to give us their most successful cases; it was often where we became the instrument of influence that just on that day triggered the parents' decision, okay, I am going to do something about my alcohol problem. I am going to do something about this. And they took their own life into their own hands and made changes.

But for the most part, the caseworker is going to have to wrap services around that family in such a way that they can custom-tailor the response, because I think it was Tolstoy that said ``Happy families are all alike; but unhappy families are unhappy in their own unique ways.'' Each of these families has a unique set of problems. And if we have cookie-cutter responses, we waste the resources and waste the child's time.

If we can figure out families on the front end, through proper assessment, and then get the most effective services; the model you describe would be very attractive. I suspect I would be talking about a lot more than $500 million authorization levels if we took that on a large scale. But the solutions for families are going to have to be tailored to their unique needs. And that takes time and attention and training.

Mr. Greenwood. Thank you, Mr. Chairman.

Chairman Hoekstra. Yes, thank you. As you have noticed, the bells are again ringing. We are going to have a series of votes on the floor. I have talked with the Ranking Member; we think it is probably best that we complete the hearing.

We would like to thank the witnesses for being here today. This is the beginning of the process; this is the first hearing on CAPTA. So we look forward to working with you throughout this process.

If there is no further business, the Subcommittee stands adjourned.

[Whereupon, at 12:12 p.m., the Subcommittee was adjourned.]

APPENDIX A -- WRITTEN OPENING STATEMENT OF CHAIRMAN PETE HOEKSTRA, SUBCOMMITTEE ON SELECT EDUCATION, COMMITTEE ON EDUCATION AND THE WORKFORCE, U.S. HOUSE OF REPRESENTATIVES, WASHINGTON, D.C.

OPENING STATEMENT OF
THE HONORABLE PETE HOEKSTRA
CHAIRMAN
SUBCOMMITTEE ON SELECT EDUCATION

HEARING ON
"CAPTA: SUCCESSES AND FAILURES AT PREVENTING CHILD ABUSE AND NEGLECT"

THURSDAY, AUGUST 2, 2001

Good Morning.

I am pleased to welcome all our guests, witnesses and members to the Select Education Subcommittee hearing on *CAPTA: Successes and Failures at Preventing Child Abuse and Neglect.*

As many of you know, one of our subcommittee's responsibilities during this year is to reauthorize the Child Abuse Prevention and Treatment Act (CAPTA). CAPTA established a focal point with the federal government to identify and address issues of child abuse and neglect, and to support effective methods of prevention and treatment.

CAPTA was last authorized in 1996 with significant changes. However, little is known as to how or if these changes are working to improve the prevention and treatment of child abuse and neglect.

Today's hearing is designed to provide an overview of how CAPTA has been implemented and administered since the last reauthorization, and to specifically look at what has worked and not worked in the prevention of child abuse and neglect. The subcommittee is also interested in hearing some suggestions as to how we can improve CAPTA during this upcoming reauthorization.

Our witnesses today are expected to share with us their expert knowledge of child abuse and neglect issues, the indicators and trends on the condition of children in the U.S., how CAPTA has helped or hurt prevention efforts, and just provide us with an overall view of where we stand today in the fight against child abuse.

According to recent statistics, almost 3 million reports of possible child maltreatment were made to child welfare agencies. Approximately 60 percent of these reports were investigated and 826,000 children were estimated to have been victims of child abuse or neglect in 1999.

Of these victims, 58 percent suffered neglect, 21 percent suffered physical abuse, and 11 percent were sexually abused.

While the overall number represents a continuation of a downward trend since 1993, the long-term trend in child abuse reporting has been one of substantial growth, with the number of maltreatment reports more than quadrupling since 1976. However, it should be noted that increased reporting does not necessarily mean an equivalent increase in actual abuse or neglect. In fact, the proportion of child maltreatment reports that are substantiated has grown smaller over time.

I do understand that some believe this number is actually higher since there is numerous cases that go undetected and reported. Despite progress in promoting child abuse awareness and the endless efforts made to prevent child abuse and neglect, much work remains.

This morning we are fortunate to have a distinguished panel of witnesses and I wish to thank each of you for taking the time to be with us. In just a few moments I will proceed with introductions, but at this time I will yield to the gentleman from Indiana, Mr. Roemer, the ranking member for any statement that he may have.

APPENDIX B -- WRITTEN STATEMENT OF THE HONORABLE WADE F. HORN, ASSISTANT SECRETARY FOR CHILDREN AND FAMILIES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Statement by

Dr. Wade F. Horn

Assistant Secretary for Children and Families

Department of Health and Human Services

Before the

House Committee on Education and the Work Force

Subcommittee on Select Education

U.S. House of Representatives

August 2, 2001

Mr. Chairman and distinguished members of the Subcommittee, thank you for the opportunity to testify on reauthorization of several programs critical to the safety and well-being of our Nation's children -- the Child Abuse Prevention and Treatment Act (CAPTA), the Adoption Opportunities Act, and the Abandoned Infants Assistance Act. President Bush, Secretary Thompson and I are committed to helping families in crisis and to protecting children from abuse and neglect. We firmly believe that every child deserves to live in a safe, permanent and caring family and greatly appreciate the interest, support and leadership demonstrated by the members of this Committee in protecting children from abuse, neglect or abandonment and in promoting adoption.

As presented in the President's FY 2002 budget, we believe the 1996 reauthorization of these programs established a strong framework for the critical services they provide and we are convinced that major changes to the legislation are not necessary. Consequently, I would like to focus my time today discussing the programs and services authorized under each of the three Acts and the progress we have made since the last reauthorization.

This is not to say that we have solved the issues of abuse, neglect and abandonment. Despite our mutual commitment to protecting and supporting American's families, these issues continue to be a significant problem in the United States and we must work together to focus our energy on sound implementation of these critical programs. However, we cannot stop there -- these issues demand a more comprehensive response.

Overview -- FY 2002 Initiatives to Strengthen Families

Before discussing the specific programs being considered for reauthorization by this subcommittee, I would like to briefly highlight several initiatives in President Bush's FY 2002 budget that will further our efforts in preventing child abuse and assisting troubled families. This Administration is convinced that a broad-spectrum approach to helping families in crisis is needed. In addition to providing for a five-year reauthorization of CAPTA, President Bush's FY 2002 budget includes four additional proposals to ensure that every child grows up in a safe and stable family.

First, to strengthen States' ability to promote child safety, permanency, and well being, the FY 2002 budget proposes funding the Promoting Safe and Stable Families program at $505 million, a $200 million increase over the current level. These additional resources will help States provide more preventative services to families in crisis, as well as enable children to be adopted more quickly into loving and committed families when that is the best option -- in both ways, increasing the prospects for children to live in a safe, permanent home. Since these funds can be used to provide a wide range of services, they certainly could support our efforts to reduce child abuse and neglect, underscoring safety in the home environment.

Within the context of the Safe and Stable Families program, the President also is proposing to provide $67 million to fund activities to mentor children of prisoners, to improve social outcomes for children and support positive family reunification. The more we focus on

strengthening the family and parenting skills, the better chances we have at reducing the incidence of child abuse and neglect.

Likewise, the President has requested $64 million to invest in strengthening fatherhood and marriage. One of the focuses of grants under this initiative will include promoting successful parenting skills to help fathers learn to better relate to their children and be positive role models.

Similarly, the President's budget provides funding to support parenting education for young mothers, who are unable to live with their own families because of abuse, neglect, or other circumstances. Maternity group homes would be funded at $33 million to ensure these mothers have access to safe and stable environments and would offer child care, education, counseling and advice on parenting skills as part of the President's multi-faceted approach to cultivating a climate that supports strong, stable families.

In addition to these new and expanded initiatives included in the President's FY 2002 budget request, the CAPTA, Adoptions Opportunities and Abandoned Infants programs play a key role in furthering the goal of this Administration to provide every child with a safe, permanent and caring family. I would now like to discuss each of these programs in more detail.

CAPTA

The Child Abuse Prevention and Treatment Act, in combination with other Federal child welfare statutes, plays an important role in our national efforts to protect children from abuse and neglect. The statute requires that the Federal-State child welfare system:

- support and improve the infrastructure of child protective services (CPS);
- develop and expand Statewide networks of community-based family support and child abuse prevention programs; and
- support research and demonstration projects designed to address the problem of child abuse and determine how best to improve the well being of abused or neglected children.

CAPTA supports this framework by providing funding for: a basic State grant program for the prevention, identification, and treatment of child abuse and neglect; the Community-Based Family Resource and Support (CBFRS) program; the Children's Justice Act grants to States; the National Child Abuse and Neglect Data System (NCANDS); research and demonstration projects on the prevention and treatment of child abuse and neglect; and a National Clearinghouse on Child Abuse and Neglect Information.

While we support the current statutory structure of CAPTA, more progress needs to be made in preventing child abuse and neglect. Tragically, in 1999, the most recent year for which we have complete data, State and local Child Protective Services agencies reported approximately 826,000 substantiated cases of abuse or neglect. While the rate of children who are victims of

substantiated or indicated abuse and neglect has been decreasing over the past decade -- from a rate of 15.3 per 1,000 identified as victims of abuse or neglect in 1993 to 11.8 per 1,000 in 1999 -- effective child abuse and neglect prevention and treatment activities must be continued and enhanced if we are to see a continued decline in child abuse and neglect. As Secretary Thompson noted, "We are encouraged by the continuing decline in the number of children who are maltreated, but it is nevertheless unacceptable that so many children are suffering."

It would be helpful to summarize the changes made by the most recent reauthorization and discuss how these changes are leading to reduced rates of maltreatment.

The 1996 reauthorization made three significant changes to CAPTA:

- First, it streamlined the Basic State grant program by replacing the annual application with a five-year plan that encourages comprehensive planning for a State's full complement of child protective and child welfare services, from prevention and protection through permanency. The CAPTA Basic State Grant is the chief Federal funding mechanism specifically targeted at improving the infrastructure of State child protective services systems – that is, the systems for receiving, assessing and investigating reports of child abuse and neglect. States may use the funds for a variety of purposes. For example, States can develop, test or implement new tools for assessing the degree of risk involved in a case, so that appropriate interventions are taken to keep children safe. Or they might use funds to provide enhanced training to CPS workers in order to respond better to families experiencing multiple

problems, such as domestic violence and child abuse, or substance abuse and child maltreatment.

- Another significant development stemming directly from the last reauthorization of CAPTA is the creation of Citizen Review Panels that provide an essential measure of citizen involvement and system accountability. Consistent with the statute, all States receiving the Basic State Grant have established panels to examine CPS agency policies and procedures and to evaluate their effectiveness in protecting children. Several States have gone beyond minimum requirements by implementing citizen review panels in every county recognizing that children and families benefit from third party review. Other States, such as Idaho, Arizona, Texas and Hawaii, report that the panels are working effectively with both their State agencies and legislatures in recommending changes in policies or procedures to improve the protection of children.

- Third, the 1996 CAPTA Reauthorization consolidated several programs including the Community-Based Family Grants, the Temporary Child Care for Children with Disabilities and Crisis Nurseries Grants, and the Family Support program into a new Community-Based Family Resource and Support grants program. The purpose of this consolidated approach was to support State efforts through a formula grants program to develop, operate and expand coordinated State networks of community-based, prevention-focused family resource and support programs using a wide variety of existing public and private organizations.

The CBFRS program focuses on primary prevention -- preventing child abuse and neglect from ever happening in the first place -- as well as prevention of the recurrence of abuse and neglect. Each State has used CBFRS funds to create a prevention network model that meets its unique needs. Based on the results of their service inventory and needs' assessment, States fund services that fill gaps in their Statewide network of prevention services. For example, in Ohio, a regional infrastructure supports public and private community-based prevention efforts in all 88 counties. In Wisconsin, the Children's Trust Fund is collaborating with the Department of Workforce Development to administer grants to local communities to support fatherhood initiatives. In California, the Office of Child Abuse Prevention encourages counties to blend a variety of State and Federal funding sources, thus maximizing the impact of these prevention funds.

The CBFRS program is relatively new, yet these family support programs are beginning to report positive outcomes in terms of participant recruitment and satisfaction -- important outcomes since participation is voluntary -- as well as changes in knowledge, attitudes, skills and aspiration. In time, these initial changes can lead to changes in behavior. For example, a parent education program for Native American parents living on tribal lands reported that over 85 percent of parents were using new methods to manage their stress as well as teaching their children to understand and manage stress. Managing stress is a critical step toward reducing child maltreatment or behaviors that could lead to maltreatment.

Many states have implemented or are implementing long-term studies and other outcome evaluation procedures with their CBFRS programs, so much more data on intermediate and long-term family support outcomes is expected within the next several years.

Children's Justice Act

The Children's Justice Act (CJA) provides grants to States to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly cases involving child sexual abuse and exploitation. States have been extremely creative in using these funds to support innovative approaches to reducing the negative impacts of child abuse and neglect. Examples of these innovations include: developing curricula and conducting cross-disciplinary training for personnel in law enforcement, child protective services, health and mental health, and the judicial system, resulting in improved communication, collaboration and resolution of cases; and, establishing or enhancing child advocacy centers and other multidisciplinary programs to serve child victims and their families, resulting in less trauma to the victims. With the passage of the Child Abuse Prevention and Enforcement (CAPE) Act in 2000, funding provided to the CJA from the Crime Victims Fund has doubled and will enable States to further these innovative efforts.

The National Child Abuse and Neglect Data System

Much of our knowledge about the number and characteristics of cases of child abuse and neglect comes from the National Child Abuse and Neglect Data System (NCANDS). The NCANDS was

established in 1988 as a voluntary data collection system on child abuse and neglect. All 50 states report aggregate and/or case-level data (34 States now report case-level data, while 17 States currently report aggregate data only).

The new data requirements specified in the 1996 amendments have been incorporated into NCANDS and, in 1999, most elements were reported on by more than half of the States. The data from the NCANDS are used by the Children's Bureau in three major endeavors:

- The Child and Family Service Reviews, the Department's new outcome-focused system for monitoring State child protection and child welfare programs, to ensure that they provide for children's safety, permanency and well-being;
- The annual report on child welfare outcomes, mandated by the Adoption and Safe Families Act of 1997 (ASFA); and
- The Government Performance Results Act.

The Child and Family Services Reviews have impacted the quality and reporting of data. States are finding the process of reviewing and analyzing their child abuse and neglect data through these reviews to be a useful and meaningful activity designed to improve child safety.

Research and Demonstration

Much of our efforts in the area of research and demonstration have been focused on the Longitudinal Studies of Child Abuse and Neglect, a consortium of research studies in five sites. This study, now in its eighth year, looks at abused and

neglected children over time. One significant finding of this research, which I believe is important in moving the field forward and improving treatment designs for children, indicates that factors such as the severity and duration of maltreatment affects child outcomes and that the significance of these factors varies by sub-type of maltreatment. For instance, a child who is neglected before age four shows more negative effects after age eight than a child neglected at a later developmental stage. If abuse or neglect is continuous, not episodic, more negative outcomes result. This information may help explain, for example, the severely debilitating effects of chronic neglect and assist States in providing better-targeted, more appropriate services.

We also are learning about promising practices related to the prevention and treatment of child neglect through 12 demonstration grants that have been underway for nearly five years. For example, chronically neglectful families appear to be more stable and stay engaged with support services when they receive a wider array of family services for longer periods of time. The services can taper off in intensity without damage to family functioning as long as they continue to cover a wide variety of issues (e.g., nutrition, housekeeping, bill paying, child-centered play activities, substance abuse and mental health support, social network building) with multiple access points to families.

Additionally, community-based groups for adolescent mothers can be successful in helping these mothers considered at high risk of neglecting their children (ages 0 to 4). These groups guide young mothers to become more stable and reliable in their child-care interactions with their

children and engage in pre-school readiness activities (e.g., helping children learn numbers and colors). Along the same lines, parent education classes that focus on school-readiness activities for neglectful mothers have shown outcomes better than expected in school-readiness among the children.

The 1996 Amendments also authorized the Secretary to award grants for projects which provide educational identification, prevention and treatment services in cooperation with pre-school, elementary and secondary schools. The demonstrations were intended to provide information about effective strategies for: (1) collaborating with schools; (2) reaching teachers, children and parents and enhancing their knowledge and skills pertaining to child maltreatment related issues; (3) enlisting school staff as active participants in efforts to prevent child maltreatment; and, (4) intervening in situations in which children are at risk for, or are victims of, maltreatment in ways that improve outcomes for these children. While the results from these 3-year demonstrations are not finalized yet, we expect to complete a report detailing the findings in the near future.

The National Clearinghouse on Child Abuse and Neglect Information

The National Clearinghouse on Child Abuse and Neglect Information was first established in 1974 to collect, organize and disseminate information on all aspects of child maltreatment in order to build the capacity of professionals in the field. Clearinghouse services are designed to be responsive to the changing needs of the field, and to meet the cross-disciplinary needs of professionals working in child abuse and neglect, child welfare and adoption. The Clearinghouse maintains extensive document collections and provides information and referrals,

technical assistance, and other products and services to meet the specific needs of users. It offers numerous materials and resources both in printed format and on-line.

Adoption Opportunities Program

I would now like to turn attention to another program the Administration is proposing to reauthorize -- the Adoption Opportunities program. With the increased attention given to adoption by the Congress, the States and private organizations, the number of adoptions has increased significantly over the past few years.

This Administration is deeply committed to promoting the timely adoption of children in foster care who are unable to return home. The Adoption Opportunities program furthers this goal by providing grants to public and private nonprofit agencies and organizations, including religious organizations. These grants are used to test new models of service delivery to address and eliminate barriers to adoption and to help find permanent families for children who would benefit by adoption, particularly children with special needs. The most recent funding initiative stressed the importance of evaluation and directed applicants to assess outcomes related to safety, permanency and well-being, whenever possible. Recent findings from two previously funded grants include the following:

- When agencies make an effort to find relatives/kin and promote kinship adoption, families can be located and responded positively. Relative adoptions can occur at greater rates than many workers believe they can be achieved.

- When these families of children to be adopted receive the kinds of support services they need or request, services available to non-kin foster families, such as respite care, the placements are more stable and families report less conflict.
- Parent-support groups are very effective in making parents feel that they have expanded resource networks and access to services and result in parents seeking out and using more community resources. Parents also report that they are better able to support and parent their children who may have special needs.

Through the Adoption Opportunities program, we will continue to stimulate innovations in recruiting and supporting adoptive families, and we will disseminate information on what works to States and organizations.

Abandoned Infants Assistance Act

The Administration also supports the extension of the Abandoned Infants Assistance Act. This program provides grants to public and community-based entities for projects to prevent the abandonment of infants and young children exposed to HIV/AIDS and drugs, and to provide services to these children and their families. Located in 18 States and the District of Columbia, these diverse programs operate out of hospitals, community-based child and family service agencies, universities, public child welfare agencies, and drug and alcohol treatment centers.

There are currently 25 comprehensive service demonstration projects providing a broad array of social and health services, including case management, child development services, job training

assistance, infant development screening and assessment, permanency planning, prenatal care, residential services, recovery support, financial and entitlement assistance, parent skills training, domestic violence services, HIV education, prevention, counseling and testing, and respite care. Two-thirds of the programs provide in-home support services, which enhance client assessment and service provision by yielding a fuller picture of the client's circumstances and addressing accessibility barriers. Transportation and child care may also be offered to assist the clients in accessing center-based services.

CONCLUSION

Addressing the needs of our Nation's most vulnerable children and families requires national leadership, comprehensive and coordinated efforts at the State and Federal level, and compassionate, caring responses from community-based organizations, including religious organizations, able to meet the specific needs of individual children and families. The Child Abuse Prevention and Treatment Act, the Abandoned Infants Assistance Act and the Adoption Opportunities Program all make important contributions to these efforts. The President's initiatives for strengthening families in the FY 2002 budget that I have highlighted will strongly enhance our work as well.

I look forward to working with the Congress to pass legislation reauthorizing these statutes and funding the President's new initiatives, so that we may further efforts to prevent child abuse and neglect and respond to it effectively when it occurs; prevent the abandonment of children

affected by HIV or substance abuse; and promote the adoption of children in foster care who need loving permanent families.

APPENDIX C -- WRITTEN STATEMENT OF DR. RICHARD J. GELLES, JOANNE AND RAYMOND WELSH CHAIR OF CHILD WELFARE AND FAMILY VIOLENCE SCHOOL OF SOCIAL WORK, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

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Committee on Education and the Workforce
Subcommittee on Select Education
"CAPTA: Successes and Failures at Preventing Child Abuse and Neglect"
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Chairman Hoekstra, members of the House Select Committee on Education, I am honored to be invited to testify today at your hearing on "CAPTA: Successes and Failures at Preventing Child Abuse and Neglect." I had the privilege to attend one of the hearings held to consider the initial version of the Child Abuse Prevention and Treatment Act in 1973, and I have testified on occasion regarding the reauthorization of CAPTA.

In many ways, CAPTA is a rather minor piece of federal legislation. The funding authorized in CAPTA is modest; in fact, we use to refer to the total amount as a mere rounding error at the Pentagon. This legislation does not focus on some of the more fundamental and controversial aspects of child protection, such as the core mission of state and county child protective service agencies. Nonetheless, CAPTA has always been

considered the centerpiece of federal legislation regarding child abuse and neglect. The definitions of child maltreatment included in CAPTA have served as a template for defining what acts of omission and/or commission warrant reporting to state child protective service agencies. While funding for research and demonstration projects are decidedly modest, the projects and issues specified by Congress in CAPTA have established the knowledge-seeking and knowledge-building agenda for researchers and practitioners.

Nearly thirty years ago, when Congress first began to formulate what was to become CAPTA, the abuse and neglect of children was a private trouble that was hidden behind closed doors. CAPTA helped elevate the tragedy of maltreatment to a social issue and ultimately to a social problem. Today, there is general agreement that child abuse and neglect is a major social problem that affects the lives of millions of children.

Generating public concern and the establishment of a child protective service system are perhaps CAPTA's major successes. Thirty years ago, child protective records were often recorded on index cards, many child welfare workers had only a high school education, and the knowledge base that workers drew upon was often laden with myths and misconceptions. At the initial hearings on CAPTA, witnesses could not even agree as to the magnitude of the problem, its causes and consequences, or what should be done to address maltreatment. Even the most expansive estimate of the extent of child maltreatment underestimated the extent by 2 million children.

Unfortunately, the successes that grew out of CAPTA have been limited. Certainly, children in the United States are better off as a result of CAPTA. On any given day, many families are helped by the child welfare system, and many children are

kept out of harm's way. In addition, there are many better-trained workers in the child welfare system.

The many successes brought about by CAPTA notwithstanding; our child welfare system is in trouble. One obvious problem is the failure to protect children from harm that is reported by local media almost weekly. Although the names and locations change, the stories are numbingly familiar--a child, usually an infant or toddler, is killed or horribly injured by his or her caregivers. The death or injury is tragic enough, but it is often compounded by the fact that the child was known to be at risk by the local child welfare agency. Occasionally, a death is so horrific that it captures national attention, as in the case of Elisa Izquierdo in New York City, or Joseph Wallace, whose mother hung him with an electrical cord in Chicago. More often than not the tragedies are local events, focusing a critical spotlight on a local or state agency and not the national system.

There are, of course, other tragedies. Children are often inappropriately removed from their caregivers. Deaths and injuries occur in foster placements and residential placements as well. It often seems that the child welfare system and workers are trapped between "a rock and the hard place" when they consider their options for providing services and protection to vulnerable children.

The troubles are not merely local. They are not the failings of individual caseworkers, supervisors, or administrators. When tragedies occur, the mantra-like claim is that the child "fell through the cracks in the system." These are not small cracks. They are national fault lines: long, deep, and always on the verge of swallowing up more victims.

The limitations of child welfare systems are well-known. Nine years

ago, the National Commission on Children reported:

> "If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system."

The U.S. Advisory Board on Child Abuse and Neglect, in its initial report to the nation in 1990, concluded that abuse and neglect constituted a "national emergency." The board stated that "in spite of the nation's avowed aim of protecting children, each year hundreds of thousands of them are being starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled." According to the report, "The system the nation has developed to respond to child abuse and neglect is failing. It is not a question of acute failure of a single element of the system; there is a chronic and critical multiple organ failure." The board's final assessment was that the safety of the nation's children could not be assured.

The crisis of child welfare is more than individual tragedies and dire pronouncements of national advisory boards and commissions. At present, at least 27 states, including many of the home states of members of this committee, are under court order to improve child welfare services

While high-profile tragedies capture media attention and are used to emphasize the conclusions of national advisory boards, failing to protect children is not the system's only flaw. Between 1,500 and 2,000 children are killed by their caretakers each year--and

half of these children are slain after they or their families have come to the attention of authorities--however child homicide, sodomy, and rape are, fortunately, still relatively rare. Neglect, starvation, abandonment, berating, and belittling are far more common. On any given day, as many as 600,000 children reside in some form of out-of-home care, largely due to their being victims of abuse or neglect. Usually they have been made wards of the government, their custody residing with the state, county, or local child welfare agency. Each year, approximately 20,000 to 25,000 children "age out" of the system. In other words, while residing in out-of-home care with their legal custody in the hands of the state, these children achieve the age of majority. At that point the state relinquishes legal custody, and the foster families or residential facilities no longer receive financial support. "Aging out" puts the former wards of the state onto the street with some assistance. In some states, the age of majority can be as young as seventeen.

Responses to Tragedy, Crisis, and Legal Action: Round-Up the Usual Suspects

When a tragedy occurs or a crisis hits, political leaders, agency administrators, and advocates tend to "round up the usual suspects" in the hope of curing the failing system. Agency heads are replaced, laws are passed, and legislatures are lobbied for more money for child welfare staff and training.

After the half-life of the tragedy subsides and the news coverage turns to other issues, the same problems persist and the same tragedies occur. The usual suspects and the new strategic plans do not work.

The Usual Suspects?

When the usual suspects are rounded-up they include the following:

- More Money. "We have too little money, we need more." Funding for child welfare never kept pace with the rising number of reports brought about by CAPTA and the complexity of child abuse and neglect cases. Thus, child welfare agency administrators are constantly trying to secure sufficient budget allocations to hire and train staff, and to develop and implement appropriate policies and interventions. To a certain extent, CAPTA's broadened definitions, technology, and public awareness campaigns bolstered the case for more funds by generating more reports, but there has always been a significant gap between resources and caseloads.
- More Staff. As funds were always short, agency administrators argued that they had too few workers to meet the demands of increasing caseloads. When a tragedy became public, the nearly automatic response was to request an increase in child protective staff. While agencies rarely received what they believed to be adequate staffing, staffing tended to increase following a tragedy.
- More Training. Additional staff would allow caseloads to be decreased, so that child welfare caseworkers did not have to carry 40 to 60 cases. In the unusual event that caseloads would meet the desired level of about 15 to 20 cases per worker (Child Welfare League of America, 1993). However, more staff did not solve the problem because child welfare workers often receive only the most minimal pre-service training before they are assigned a caseload. It is not unusual for a child welfare worker to get 20 hours of training before being assigned a full caseload. In-service

training is also minimal. Thus, agency workers and directors would often respond to a crisis with a call for new and more training for workers.

- Blame the Judges and/or the Laws. The final "usual suspect" is the legal system, or "the judges." Child welfare workers and administrators frequently identify their core constraint as the legal system and the on or inaction of judges. Case workers claim that the law requires them to make "every possible effort" to keep families together. They also claim that judges ignore caseworkers' recommendations. Many child welfare critics' claim that legal reform and judicial training is the solution,

A case can be made for all of the above arguments. The child welfare system is under-staffed, under-funded, under-trained and limited by legal constraints and judicial decisions. Yet, each of the above problems has been addressed over the past three decades with little measurable impact. As important as the "usual suspects" are, they do not constitute the real "offender" that causes the child welfare crisis.

Out-Of-The-Box: New Thinking for Reforming the System

The time has come for new solutions. Swinging the pendulum from child safety to family preservation has not succeeded. Replacing treatment programs such as Homebuilders with Family Group Conferencing is unlikely to succeed. Child welfare reform can only be achieved by identifying the true weaknesses of the system and applying out-of-the box thinking to the problem solving

Any system is only as strong as its weakest link. The weakest link of the child welfare system is the individual worker.

It is only a slight hyperbole to characterize the typical front-line child welfare workers as a 25 year-old Art History major. Obviously, there are many seasoned and mature front-line child welfare workers that have a wealth of experience to draw upon in their work. On the other hand, it is equally true that the field of child welfare has not been professionalized in the past 30 years. For all the increases in the number of workers in child welfare and in funding for child welfare agencies, front-line child welfare workers still enter homes severely lacking in training, insight, and the proper skills to assess risk and family needs.

Schools of Social Work in the United States bear much of the responsibility for the dearth of professionally trained front-line child welfare workers, and for the fact that the field of child welfare has not been professionalized during the time child abuse was transformed from a personal trouble into a social problem. By and large, Schools of Social Work remain focused on turning out clinicians trained for either private clinical practice or administration. Until Schools of Social Work commit themselves to instituting a professional child welfare track and appropriate curriculum, rounding-up the usual suspects, in the form of hiring additional workers, will yield more of the same well-intended but poorly prepared workers.

Even if child welfare workers are adequately prepared to undertake front-line work, when they go about their business, they open a toolbox that provides only limited tools. The core of a child protective worker's responsibilities is to investigate and assess the suspicion that a child was abused or neglected and then to determine the level of risk to the child and the services the caregivers may require. Again, it is not entirely an exaggeration to say that many front-line child welfare workers employ what I call

"olfactory" risk assessment. How neat a house is and how it smells may be the most important factor in the risk assessment process. Many states have implemented formal risk assessment tools, but almost all the tools are lacking in that they: (1) Are not psychometrically sound—that is they are not reliable and valid measures of risk; and (2) They can all be subverted in the field by the workers. No matter how psychometrically sound a risk assessment is, a worker can subvert it by arriving at a subjective sense of risk and then completing the form to attain the desired risk score.

Even if the worker objectively completes a psychometrically sound risk assessment, nearly all risk assessment instruments are limited and naive with regard to assessing the caregiver's willingness and capacity to change. Many child welfare workers believe in the following three principles:

1. Parents want to and can change their abusive and neglectful behavior. At the core of child welfare work is the belief that most, if not all, parents want to be good and caring parents and caretakers. Whether maltreating behavior is thought to arise from psychological causes, alcohol or substance abuse, or social or structural stresses, the child welfare system is structured under the assumption that parents want to change their behaviors. As a result, both the hard and soft services offered by the child welfare system assume that parents want to receive and can make use of resources, such as therapy, parenting classes, homemaker services, and advocacy.
2. Changes can be achieved if there are sufficient resources. The second belief follows directly from the first. If parents and caretakers want to change, then the only constraint or roadblock to change is the lack of resources. If change does not occur, it

is attributed to a lack of soft or hard resources, not to the parents' lack of willingness or ability to change

3. A safe and lasting family reunification can be achieved if there are sufficient resources. Given the first two beliefs, the child welfare system believes that if the system has sufficient personnel and service resources, children could be safely kept at home or returned home to their parents.

In reality, change in general, and change in the particular case of caregivers that maltreat their children, is much more difficult to bring about. A substantial body of research provides evidence that people in general, including abusive and neglectful parents are difficult to change. These data counter the notion that all parents want to and can change their behavior. A major failing in child abuse and neglect assessments is the crude way behavioral change is conceptualized and measured. Behavioral change is thought to be a two-step process--one simply changes from one form of behavior to another. For example, if one is an alcohol or substance abuser, then change involves ceasing to use alcohol or drugs. If one stops, but then begins again, then the change has not successfully occurred. Change, however, is not a two-step process. All individuals are not equally ready to change. Although there is a general belief that change can be achieved if there are sufficient soft and hard resources, as yet, there is no empirical evidence to support the effectiveness of child welfare services in general or the newer, more innovative intensive family preservation services. The lack of empirical support for the effectiveness of intensive family preservation services was the finding of the National Academy of Sciences panel on Assessing Family Violence Prevention and

Treatment Programs, and the United States Department of Health and Human Services national evaluation of family preservation programs.

The last and most important weakness of front-line services is the limited ability of front-line workers to provide close monitoring of child welfare cases. Federal guidelines require that state and county child welfare agencies have caseworkers visit and see children in the child welfare system at least once per month. Most child welfare agencies are unable to deliver even this limited level of case monitoring. In Philadelphia, workers see only half the children in the child welfare system once a month—the remainder is seen less frequently. The lack of monitoring and contact creates one of the greatest and widest structural chasms in the child welfare system.

Solutions

Money alone will not reform the child welfare system; Class action lawsuits and consent decrees have not yielded the desired changes and reforms. Reform must be built into the system from the ground up.

As Congress considers the reauthorization of CAPTA, there are some critical issues that should be considered:

1. Is CAPTA's definition of child abuse and neglect too broad? While CAPTA has indeed led to increased reporting, less than half of the nearly 3 million reports made annually are substantiated upon investigation.
2. Is mandatory reporting working? The effectiveness of mandatory reporting has been a matter of faith for more than 30 years. Yet, the actual result of mandatory

reporting laws has never been scientifically examined. No more than three other nations in the world have mandatory reporting laws. Are we correct and the rest of the world behind, or have we erred in placing so much emphasis and resources at the front end of the system.

3. Are there technologies available that can aid the child welfare system in assessing reports, conducting risk assessments, and monitoring children at risk? The major technology of child welfare is the telephone and pager. Data management systems, such as AFCARS and SACWIS were developed in a pre-internet environment, and many states are spending millions of dollars to comply with federal requirements that pre-date current computer technology.
4. Are the provisions of CAPTA consistent with the Adoption and Safe Families Act? Four years after the passage of ASFA and five years after CAPTA's reauthorization, child protective workers and administrators are still unclear regarding their primary obligation to children and families. Despite ASFA, a significant number of children still remain in foster care for more than 18 months.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Richard J. Gelles		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No X
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1998: U.S. Department of Justice, National Institute of Justice		
3. Will you be representing an entity other than a government entity?	Yes	No X
4. Other than yourself, please list what entity or entities you will be representing:		
5. Please list any offices or elected positions held and/or briefly describe your representational capacity with each of the entities you listed in response to question 4:		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1998, including the source and amount of each grant or contract: U.S. Department of Justice, National Institute of Justice September, 1999 to August, 2002 $297,208		
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing? If so, please list:	Yes	No

Signature: R J Gelles Date: 8.1.01

Please attach this sheet to your written testimony.

APPENDIX D -- WRITTEN STATEMENT OF MR. PATRICK FAGAN, WILLIAM H.G. FITZGERALD RESEARCH FELLOW, FAMILY AND CULTURAL ISSUES, HERITAGE FOUNDATION, WASHINGTON, D.C.

The Heritage Foundation

The Heritage Foundation 214 Massachusetts Avenue, N.E. Washington, D.C. 20002-4999 (202) 546-4400

Congressional Testimony

CAPTA Successes and Failures at Preventing Child Abuse and Neglect

Testimony before

The House Committee on Education and the Workforce

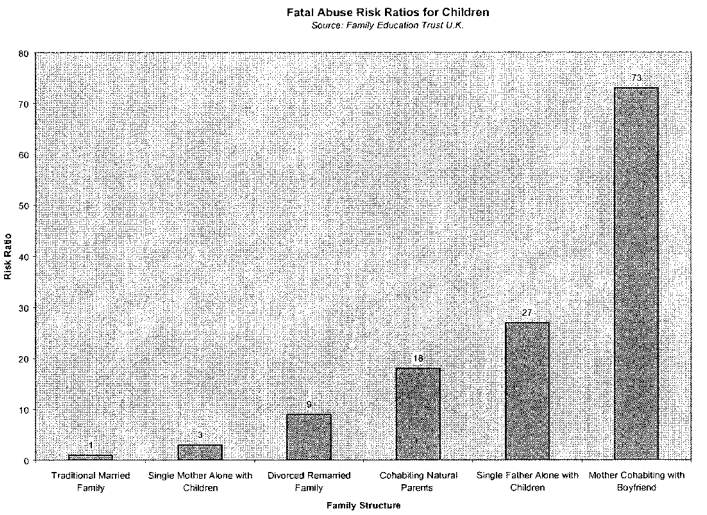
Pat Fagan
The Heritage Foundation
214 Massachusetts Ave. N.E.
(202) 546-4400

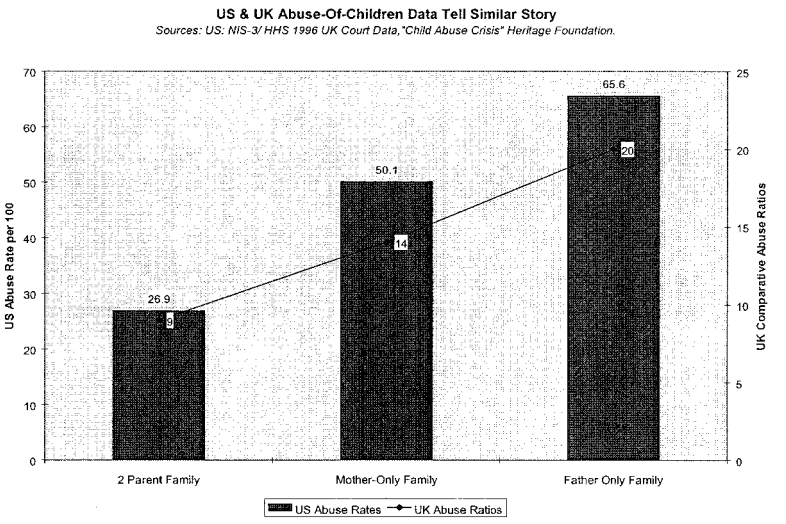
Family Structure and the Role of Parents

We do know that rates of abuse for children are lowest in intact married families. We know that abuse is highest when mother cohabits with a boyfriend who is not the father of the children. This family arrangement is very frequent among the poor, thanks in no small part to the role of the federal government.

Federal welfare payment structures and Earned Income Tax Credit (EITC) regulations massively penalize marriage, and in so doing the federal government has an active role in fostering the family structures that feed child abuse the most.

If the federal government wants to see a decrease in the rates of child abuse, logically, it must commit itself to restoring marriage particularly amongst the poor: restoring commitment, loyalty and security. Both abused women and children will benefit.





United Nations and Parental Rights

For decades now among some child advocates there has been a growing hostility towards parents and a dismissal of the rights of parents. This runs from local cases such as described above to the infamous 1980 Washington State Supreme Court judgement against the parents of Sheila Marie Sumey,[1] when the child was removed from her parents at her own request, acknowledged to be without cause on the parents side of the issue. Though history, and the now grown teenage girl both clearly state the courts were wrong, the precedent still stands in Washington State and the court has not renounced its error.

At the United Nations the rights of parents to raise their children according to their moral and religious beliefs is constantly under attack from the U.N. Secretariat.[2] For instance the committee tasked to bring nations into compliance with the Convention on the Rights of the Child (which the US has not ratified) rebuked Great Britain for permitting parents to withdraw children from sex-education classes that ran counter to their moral beliefs, even though the rights of parents to direct the moral formation of children is enunciated

[1] *In re the Welfare of Sheila Marie Sumey*, 94 Wash. 2d 757, 621 P.2d 108
[2] For a review of the pattern see: Patrick F. Fagan, "How U.N. Conventions on Women's and Children's Rights Undermine Family, Religion and Sovereignty", Backgrounder # 1407, The Heritage Foundation, Feb. 5 2001,

in the Universal Declaration of Human Rights and in the two treaties which implement the Declaration. The U.N. Secretariat has never countermanded the committee rebuke.

In 1998 at the U.N. Lisbon conference of Ministers of Youth the rights of parents to form their adolescent children was repeatedly fought off and deliberately not included in the final concluding document.

Furthermore the U.N. committees are urging states to give minor children:

- The **right to privacy**, even in the household;
- The **right to professional counseling** without parental consent or guidance;
- The **full right to abortion** and contraceptives, even when that would violate the parents' ethics and desires;
- The **right to full freedom of expression** at home and in school;
- The **legal mechanisms** to challenge in court their parent's authority in the home.

For example, the U.N. Committee on the Rights of the Child recommends to the Japanese government that it "guarantee the child's right to privacy, especially in the family."[55] Such a measure would establish legal and structural wedges between parents and their children in the home. Normally, when children rebel against their parents, society frowns. Yet the U.N. is attempting to put in place, in policy and law, structures that foster this type of rebellion.[3]

These are not distant threats to the rights of parents, they are as close as the Convention on the Rights of the Child already signed by President Clinton, though not ratified by the Senate.

There are dangerous attitudes of hostility towards the roles and rights of parents, attitudes growing among many in the applied fields of children's policy and in the policy community of children's advocates at the national and international level. Because Congress funds so much of the programs that interface the rights of children and the rights of parents it behooves it to protect the constitutional rights of due process of parents.

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[3] ibid p.10

National Incidence Survey (NIS – 4)

One of the first things that the federal government can do is direct HHS to do the fourth round of the National Incidence Survey, (NIS-4) and this time require that data be gathered on two critical background factors in abuse: details on the marital living arrangement of resident parent(s), (there are at least eight such arrangements that are critical in child abuse) and the frequency of religious worship by the resident adults. There is a need to get a true and accurate picture of the structures of abuse in this country. The prior three Surveys did not gather these data and to that extent the country is flying blind and misinformed on the need to cultivate those institutions that are most protective of the safety of children, women and even men.

Anonymous tips

The highest substantiation rates of reports of abuse come from professionals who report their concerns, while the lowest level of substantiation of abuse comes from anonymous reports.

A huge proportion (70 percent on average, and up to 90 percent in some districts) of the investigations of child abuse triggered by anonymous reports turn out to be without foundation and these investigations eat up a massive amount of the resources needed to deal with real child abuse and neglect.

When an innocent family is confronted with police and social workers in a basless case they are frequently frightened needlessly. Furthermore when they are treated with the presumption to be felons (when they are innocent) each such treatment erodes citizens confidence in the child protective service and even in law enforcement. This sense of distrust has been growing for a number of years among traditional church-going families and particularly among homeschooling families (who as a group are the superior performers on raising their children), a distrust that should be of concern to all lawmakers and law enforcement officers and court officers.

At the heart of this particular type of overuse is the widespread, well nigh universal practice of permitting anonymous callers to lodge complaints. This practice permits a miscarriage of justice: a call can be made accusing a parent of awful abuse of their children. Case workers, sometimes accompanied by police then have to investigate the complaint, and as mentioned, over 70 percent of them are baseless. Many such initial reporting are malicious in nature.

There is a simple remedy: anonymous calls to the case worker or police should not be acted upon. One might still protect the anonymity of the caller from the accused but at least the police or case workers should know who the caller is and how to contact them.

New Mexico and Arizona have laws on the books against the use of malicious calls but because anonymity of the caller is permitted, malicious calls generally cannot be prosecuted or even investigated.

It is time to require callers who accuse or report abuse to identify themselves to the officials they call.[4] Doing so will likely bring the rate of confirmable reports.

False reports should at least be a class C misdemeanor. (Alabama has model legislation).[5]

Due Process Rights

A related abuse of law is that parents are not informed of their rights when investigators call. For instance recently in Missouri a parent was anonymously accused of spanking his child 250 times of chaining the children to chairs and of emotionally abusing them in other ways. Two social workers, a sheriff and two criminal investigators showed up at the door and claimed right of entry. The show of force was overwhelming to the mother who answered the door. The case was eventually judged to be baseless and malicious but only after much trauma to the children and family was this finally the judgement of the police and caseworkers. In other cases when parents know and exercise their rights and refuse entry they are sometimes subject to harassment and abuse by the investigators.[6]

The proper approach would be to remind parents of their rights (that they do not have to let investigators into the home, and that they do have the right to counsel before proceeding further). Thereafter investigators may try to persuade parents to permit them to investigate and bring the issue to swift close.

These two reforms would massively reduce the unnecessary investigation caseload and help restore the confidence of parents in the child protection system.

Furthermore it would restore due constitutional process to parents, the one group that does not have this fundamental civil right extended to them.

A warrant must be obtained before a home can be entered without the informed consent of the parents, especially in the case of anonymous reports.

To help redress violations of privacy, victims of such violations should be able to inspect their records in order to seek recourse and rectification of the record.

An articulation of parental rights is needed to level the playing field during child welfare investigations.

---

[4] See Missouri H.B 30 for model legislation.
[5] Alabama, S. 679
[6] The HomeSchool Legal Defense Fund has ample case histories of such abuses from their legal consulting practice.

The other end of the spectrum of the treatment of parents is where they have been repeatedly found guilty of serious child abuse. There the needs of the child demand that parental rights be terminated and the child placed for adoption much more frequently than they are. Thus on one end the system is overzealous too frequently and on the other end it is lacking in courage to do what it is empowered by law to do and what the needs of the child demand.

States Rights

There is a conservative tradition of defending the rights of states in all things that are not the purview of the federal government. I agree with that tradition and see a critical need to return to it. However there is no immediate chance that the federal government funding on child abuse issues will disappear or even be reduced. Therefore the federal government should use the influence it has through funding to ensure that the constitutional rights of parents are protected, both in due process issues and in ensuring that the wheels of justice turn in as just manner for parents being investigated as they do for arraigned criminals.

Furthermore many states are failing the best needs, even the minimal needs, of children by not aggressively pursuing the severance of parental rights when severe and repeated abuse of young children has been established. Such states violate the rights of the most vulnerable who are already under the protection of the state. This state neglect is cause for federal concern, further investigation, deliberation and action.

The views that I express in this testimony are my own, and should not be construed as representing any official position of the Heritage Foundation. In addition, the Heritage Foundation does not endorse or oppose any legislation.

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Government	0.0%
Individuals	51.2%
Foundations	17.0%
Corporations	3.2%
Investment Income	25.9%
Publication Sales and Other	2.7%

The top five corporate givers provided The Heritage Foundation with less than 1.6% of its 2000 income. The Heritage Foundation's books are audited annually by the national accounting firm of Deloitte & Touche. A list of major donors is available from The Heritage Foundation upon request.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own, and do not reflect an institutional position for The Heritage Foundation or its board of trustees.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name:		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No ✓
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1998: NONE		
3. Will you be representing an entity other than a government entity?	Yes	No ✓
4. Other than yourself, please list what entity or entities you will be representing:		
5. Please list any offices or elected positions held and/or briefly describe your representational capacity with each of the entities you listed in response to question 4: PAST: DEPUTY ASSIST. SEC. FOR SOCIAL SERVICES POLICY. HHS. 1989 – 1993. (BUSH ADMINISTRATION)		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1998, including the source and amount of each grant or contract: N/A.		
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing? If so, please list:	Yes	No ✓

Signature: Patrick J Fagan Date: Jan 31 2001.

Please attach this sheet to your written testimony.

****

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Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own, and do not reflect an institutional position for The Heritage Foundation or its board of trustees.

APPENDIX E -- WRITTEN STATEMENT OF MR. CHARLES WILSON, DIRECTOR, CENTER FOR CHILD PROTECTION, CHILDREN'S HOSPITAL AND HEALTH CENTER, SAN DIEGO, CALIFORNIA

TESTIMONY OF CHARLES WILSON
DIRECTOR, CENTER FOR CHILD PROTECTION
CHILDREN'S HOSPITAL AND HEALTH CENTER-SAN DIEGO

HEARING BEFORE THE
SUBCOMMITTE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
THURSDAY, AUGUST 2, 2001

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)
2001 REAUTHORIZATION

Good morning. My name is Charles Wilson. I want to begin by thanking you for inviting me to participate in this hearing on the reauthorization of the Child Abuse Prevention and Treatment Act.

I am the director of the Center for Child Protection at San Diego Children's Hospital and Health Center. Previously, I served as director of the National Children's Advocacy Center in Huntsville, Alabama, and my work of almost thirty years in this field has also included service as the director of family services, and of child welfare, in the Tennessee Department of Human Services. In addition, I appear before you today on behalf of the National Child Abuse Coalition, representing a collaboration of national organizations concerned about the future of services for treating and preventing child abuse, and the National Call to Action, a coalition of 30 national organizations working together to implement a 20-year action plan to drastically reduce the prevalence of child abuse and neglect.

We call on Congress to reauthorize the Child Abuse Prevention and Treatment Act (CAPTA) to provide core funding:

1. for the child protective services (CPS) infrastructure,
2. for community-based services in prevention, and

3. for support of research and the development of innovative programs to advance the field of prevention and treatment of child abuse and neglect.

Child maltreatment is a serious public health problem. U.S. Department of Health and Human Services reports that CPS agencies received 2.975 million reports of suspected child abuse and neglect in 1999, of which 1.796 were screened in for further assessment and investigation. Following investigation, an estimated 826,000 children were found to be victims of abuse and neglect. Fatalities due to child abuse and neglect claimed the lives of an estimated 1,100 children in 1999 – 3 deaths each day. Children under one year of age accounted for 42.6 percent of those deaths.

These are the abused and neglected children who come to the attention of communities across the country for protection form further, even more serious harm. HHS also reports that many more children – whether known or unknown to protective services – are abused and neglected each year: 1.55 million maltreated children in the United States according to the 1996 Third National Incidence Study of Child Abuse and Neglect .

These numbers – and the lives of these children – can not be taken lightly or dismissed.

The incidence of child abuse and neglect exceeds the capacity of our system to respond. HHS reports that the average time from start of investigation to provision of service is 47.4 days. Less than half (44.2%) of child victims receive no services. A CAPTA-funded 2001 study shows that job stress related to the number and composition of a child protective service worker's caseload affects decisions on substantiation of maltreatment reports. The same study reveals that a perceived lack of service resources in a community may be tied to an increased recurrence of reports.

Current spending for CPS in federal, state and local dollars falls short by about $2.56 billion of the estimated $5.215 billion total cost. According to the Urban Institute's February 2001 report, *The Cost of Protecting Vulnerable Children II: What Has Changed Since 1996?*, states reported spending $15.6 billion on child welfare in 1998, and they could categorize how $13.6 billion of the funds were used. Of that amount, 63 percent was spent for out-of-home placements, 11 percent on administration, 9 percent on adoption, and 17 percent – or $2.652 billion --on all other services: that is, for child protective services and preventive services combined. (Of the $15.6 billion, states spent $7.1 billion in federal funds, $6.5 billion in state funds, and $1.7 billion in local funds).

Data indicate that effective investigations by child protective service agencies should cost approximately $990 per case. The cost per case to provide good basic in-home services such as homemaker assistance or family counseling should be $3,295. The expense of investigating the 1.796 million children who were screened in for further assessment of the 2.975 million reports of suspected child abuse and neglect in 1999, plus the expense of providing services to the 826,000 child victims and the 217,000 children in unsubstantiated reports who also received some services, would total $5.215 billion. Yet, in 1998, states reported spending $2.652 billion in federal, state and local dollars for child protection (and prevention), falling short of the need by about $2.56 billion.

The CAPTA statute must be updated to reflect the current situation for treatment and prevention of child abuse and neglect. Federal laws have created a system of child welfare support heavily weighted toward protecting children who have been so seriously maltreated they are not safe at home and must be placed in foster care or adoptive homes. These are children whose safety is in danger; they demand our immediate attention. Unfortunately, far less attention in federal funding and policy is directed at preventing harm to these children from happening in the first place, or

providing the appropriate services and treatment needed by families and children victimized by abuse or neglect.

Important changes in federal child welfare policy were made with the enactment in 1997 of the Adoption and Safe Families Act. However, current child welfare funding in all sectors is inadequate to provide the money states need to respond to time limits and outcomes required by the Adoption and Safe Families Ac. Under current law, Title IV-E child welfare funding cannot be used to support these service needs. CAPTA, with a focus on support to improve the CPS infrastructure, could be the source to help in providing those resources for prevention, intervention, and treatment.

CAPTA BASIC STATE GRANT PROGRAM

CAPTA should be the core source of funding for child protective services, yet it is not. CAPTA funding for basic state grants at the current level of $21 million is not up to addressing the scope of the need for support of CPS. The National Child Abuse Coalition believes that an annual authorized funding level of $500 million is a realistic approach to developing the CAPTA basic state grant program as a source of core funding for child protective services. A commitment at this level of funding will begin to help close the gap between what federal, state and local dollars currently allocate to protect children and treat child victims, and what those services cost.

CAPTA basic state grants are used for developing innovative approaches in child protective services systems. This is potentially an important source of support for improving the child protective service system from state to state. Through the CAPTA basic state grant program, the federal government has the opportunity to step up to a leadership role in providing support for the CPS system infrastructure and to begin to rectify the imbalance in the federal government's response to the abuse and neglect of children.

In addition to authorizing meaningful appropriations for the basic state grants to help improve the CPS infrastructure, the National Child Abuse Coalition proposes a focus on the purpose of those grants to enable states to improve their CPS systems, through CAPTA grant support, in a variety of activities essential to a responsive, efficient and appropriate protective service system. In addition to the purposes for basic state grants in current law which address CPS improvements, the Coalition proposes that CAPTA funds be available to address the following issues:

CPS staffing: to improve upon the supervision of cases work in CPS; to enhance the recruitment and retention of child protection workers; and to promote competency-based training for child protective service work.

Case management: to promote on-going case monitoring and service delivery; to enhance the ability to assess cases; to improve upon the management of case information; and to help states develop common databases for information.

Linkages: to promote partnerships between CPS and private, community-based services; and to develop connections with services to support comprehensive health evaluations of abused and neglected children.

Public education: to improve upon the public's understanding about the role and responsibilities of CPS; and to inform the public about appropriate reporting of suspected incidents of child maltreatment

CAPTA COMMUNITY-BASED FAMILY RESOURCE AND SUPPORT PROGRAM (Title II)

CAPTA should be the basic source of funding for community-based prevention programs, yet its resources are inadequate. Current funding community-based prevention program at $33 million is insufficient to the task of truly preventing abuse and neglect of children from happening in the first place. The National Child Abuse Coalition believes that annual authorized funding of $500 million represents a modest commitment to support prevention of child abuse and neglect through CAPTA

The cost of preventive services if offered to the more than 3 million child maltreatment victims identified in the HHS National Incidence Study 3 would total over $9 billion, far more than the $2.652 billion states reported spending for child protection and prevention in 1998.

Even that would be a small price to pay when we consider the human and dollar costs of the consequences of child abuse and neglect. According to a report this year from Prevent Child Abuse America, the direct costs of intervening to help, and of treating the medical and emotional injuries of abused and neglected children, as well as the indirect costs associated with the long-term effects of abuse and neglect, total an annual expense to our society of over $94 billion.

Preventing the abuse and neglect of children from happening in the first place will keep children safe and avert the consequences of child maltreatment. Research into the results later in life for children who have been maltreated show that:

1. Child abuse prevention can help to prevent crime. Victims of child abuse are more likely to become juvenile offenders, teenage runaways, and adult criminals later in life.

2. Abused and neglected children may experience poor prospects for success in school, typically suffering language and other developmental delays, and a disproportionate amount of incompetence and failure.
3. Preventing child abuse can help to prevent disabling conditions in children. Physical abuse of children can result in brain damage, mental retardation, cerebral palsy, and learning disorders
4. Preventing child abuse helps prevent serious illnesses later in life. Recent research links childhood abuse with adult behaviors which result in the development of chronic diseases that cause death and disability.

The CAPTA Community-Based Family Resource and Support Program prevention grants should assist states and communities to develop successful approaches to preventing child abuse and neglect through such essential community-based, family-centered, prevention services as support programs for new parents, parent education, respite child care, home visitor services, parent mutual support, and other family support services.

We know that prevention works. Studies of home visiting programs suggest that the risk of child maltreatment is two to three times higher among children living in families not receiving services compared to those enrolled in a program. Crisis nurseries have been demonstrated to protect children against abuse at home. A survey of high-risk families participating in a crisis nursery in Oregon found that 95% of the hundreds of children enrolled had no reports of abuse or neglect. A study of Iowa crisis care programs indicate a 13% decrease in child abuse in four counties offering services.

CAPTA RESEARCH AND DEMONSTRATION GRANTS FOR INNOVATIONS

CAPTA is the only federal program for support of research and innovations to improve practices in preventing and treating child abuse and neglect, yet funding remains insufficient. CAPTA dollars for R&D at the current funding of $33 million is inadequate to satisfy the need for advancing our knowledge and improving services for protecting children. At the current funding level, HHS is able to fund only one out of eight applications for field-initiated research. Raising the authorized appropriations to the level of $100 million would help to advance the field's knowledge through support for research and program innovations, as well as funding for the training, technical assistance, data collection and information sharing functions also authorized by CAPTA out of this money.

CAPTA funding is an efficient means of enabling states and communities to improve their practices in preventing and treating child abuse and neglect. The discretionary grant program supports a broad array of leadership activities which are uniquely suited to the federal government's national perspective and ability to address current issues through a variety of strategies -- program development, research, training, technical assistance, and the collection and dissemination of data – in order to advance the field of prevention and treatment of child abuse and neglect.

Public agencies beleaguered by the crises of the day often do not have the capacity to undertake such activities, but they benefit from tested approaches, like those CAPTA supports. These discretionary grants help ensure that the CAPTA state grant funds and other child protection investments will actually benefit children.

Over the years, important strategies in child abuse prevention and protection of children which have developed with seed money from CAPTA. The history of CAPTA funding demonstrates the value of this investment.

- Early in the development of the Parents Anonymous program, CAPTA support helped to enable this parent mutual support-shared leadership organization to expand, through technical assistance and training, beyond its beginnings in southern California to become today an important prevention resource for families in communities nationwide - serving 60,000 parents and children in 1999.

- An initial grant from CAPTA helped the first children's advocacy center developed in Huntsville, Alabama by then-district attorney and now Rep. Bud Cramer (D) to serve as the model program for centers protecting children in states across the country.

- In Hawaii, seed money from CAPTA went to develop the successful program of home health visitors which has been adopted through Healthy Families America in hundreds of communities in 39 states to help parents get their children off to a healthy start.

Research Grants

The National Child Abuse Coalition proposes amending CAPTA to focus research on current topics important to improving our ability as a caring society to protect children and prevent abuse and neglect. Among appropriate topics which should be addressed by CAPTA research funding are the following:

1. longitudinal research, to enable us to understand better the outcomes for maltreated children.
2. decision-making procedures (including multi-disciplinary, coordinated decision-making) in cases of child abuse and neglect, to improve upon the ways in which abused and neglected children and their families are treated.
3. evaluation of programs to identify effective approaches for prevention, intervention and treatment, to spread knowledge about successful strategies.
4. development of best practices for achieving improvements in child protective service systems, to help society's ability to protect children from harm and to prevent the recurrence of abuse or neglect.
5. an environmental analysis of the field of child abuse and neglect, to identify redundancies and gaps in services and information toward the improvement of efforts to prevent child abuse and neglect, protect children, and treat the effects of maltreatment.

Demonstration Grants

The National Child Abuse Coalition proposes new language in CAPTA to emphasize that demonstration grants should address prevention of child maltreatment and the protection and treatment of child victims of abuse and neglect. The focus of CAPTA and the value of the federal leadership through CAPTA in the nation's effort to protect children from harm should not be diluted.

Further, to address needs often overlooked in the response to protecting abused and neglected children, we propose amending CAPTA to address priorities in:

1. enhancing linkages between CPS and health care services for abused and neglected children;.

2. promoting collaborations between CPS and community-based as well as national programs, statewide child abuse prevention organizations, law enforcement agencies, substance abuse treatment services, health care services, domestic violence services, mental health services, developmental disability agencies, in addition to those already named in CAPTA;
3. developing systems to promote treatment services and attention to the child victim's well-being and safety; and
4. supporting hospital-based model approaches for forensic diagnosis and comprehensive health evaluations in child abuse and neglect cases.

The technical assistance offerings, evaluation measures, and information dissemination functions supported by CAPTA should address these priorities as well. The statute should focus on improving the evaluations of CAPTA-funded demonstration grants, the replication of successful model programs, and the distribution of information on programs with potential for broad-scale implementation and replication.

MEDICAL NEGLECT

Finally, the National Child Abuse Coalition urges removing language from CAPTA with the effect of allowing states to permit parents to withhold medical care from sick and injured children on religious grounds.

A 1998 article in the *Pediatrics* journal cites the records of 172 children who died between 1975 and 1995 and whose parents withheld medical care because of their religious beliefs. In assessing the probability of survival for each based on expected survival rates for children with similar disorders who receive medical care, the researchers concluded that 142 fatalities were from conditions for

which survival rates would have exceeded 90 percent. Eighteen more had expected survival rates of 50 percent. All but three of the remainder would likely have had some benefit from clinical help.

CAPTA's Section 113 unnecessarily endangers the health of a certain group of children -- those whose parents have religious objections to medical care. While CAPTA requires states to protect all other children from medical neglect, these children are not entitled to this protection. Yet, the U.S. Supreme Court has held that the First Amendment does not allow one's religious practices or beliefs to endanger one's children. Prince v. Massachusetts, 321 U.S. 158 (1944). Under this long-standing Supreme Court doctrine, Congress need not, and should not, weaken the protection of children whose parents hold religious objections to medical care.

CONCLUSION

CAPTA has an important role to play in the federal response to the prevention of child maltreatment and the protection of abused and neglected children. Unfortunately, the federal role bears almost no relationship to the extent of the problem of child maltreatment in our society. While the numbers of children abused and neglected each year in the United States remain high, federal budgetary policy remains focused on paying billions of dollars for the removal of children from homes where they are no longer safe. Relatively few federal resources are directed at helping states and communities in their response to protecting children at the first instance of harm, or preventing that harm from happening at all.

The prevention of child abuse requires intensive effort and the commitment of resources such as we rarely see in government, certainly more than is allocated to date through CAPTA.

We are at a point now where we can act to improve upon the federal support and leadership. We urge your adoption of legislation to amend CAPTA in ways that will truly assist states and communities in their efforts to keep children from harm. We stand ready to assist this subcommittee and your colleagues in Congress in developing a new federal role for protecting children and preventing child abuse.

THE SPENDING GAP IN CHILD PROTECTIVE SERVICES

Current spending in federal, state and local dollars for child protective services (CPS) falls short by about $2.56 billion of the estimated $5.215 billion total cost.

The National Child Abuse Coalition believes that an annual authorized funding level of $500 million is a realistic approach to developing the CAPTA basic state grant program as a source of core funding for child protective services. A commitment at this level of funding will begin to help close the gap between what federal, state and local dollars currently allocate to protect children and treat child victims, and what those services cost.

How is the CPS spending gap determined?

In formulating appropriate funding levels for CAPTA in the coming years, it is useful to consider the cost to child protective services of 1) investigating reports of child abuse and neglect and 2) providing basic services to the victims of child maltreatment. Then, when we look at the actual dollars spent, we can determine the gap in funding which accounts for many of the barriers to the protection of children and the prevention of child maltreatment.

How many children are referred to CPS for abuse or neglect?

HHS reports that CPS agencies received 2.975 million reports of suspected child abuse and neglect in 1999, of which 1.796 million were screened in for further assessment and investigation. Following investigation, an estimated 826,000 children were found to be victims of abuse and neglect. The HHS report also tells us that 217,000 children in unsubstantiated reports received some services. In addition, we know that over 365,000 victims of child abuse received no services in 1999. *U.S.DHHS (2001). Child Maltreatment 1999. Washington, DC. U.S. Government Printing Office.*

How much do states spend on CPS?

According to the Urban Institute's February 2001 report, *The Cost of Protecting Vulnerable Children II: What Has Changed Since 1996?*, states reported spending $15.6 billion on child welfare in 1998, and they could categorize how $13.6 billion of the funds were used. Of that amount, 63 percent was spent for out-of-home placements, 11 percent on administration, 9 percent on adoption, and 17 percent – or $2.652 billion --on all other services, including prevention. (Of the $15.6 billion, states spent $7.1 billion in federal funds, $6.5 billion in state funds, and $1.7 billion in local funds).

What should a report of abuse or neglect cost a CPS agency?

Data indicate that investigations by child protective service agencies cost approximately $990 per case. The cost per case to provide basic in-home services such as homemaker assistance or family counseling is $3,295. *Courtney, M.E. (1998). "The Costs of Child Protection in the Context of Welfare Reform". The Future of Children, Vol. 8, No. 1.*

The total cost of CPS services at $5.215 billion is based on applying these costs to the reporting information from HHS for 1999: investigating 1.796 million reports; and providing some level of service to the 826,000 confirmed cases of child abuse and neglect, and to the 217,000 children in unsubstantiated reports who received post-investigative services.

The Spending Gap In Child Protective Services

Reports of Suspected Child Abuse & Neglect [1]	2.975 Million	
Child Abuse & Neglect Cases Investigated [1]	1.796 Million	
Confirmed Cases of Child Abuse & Neglect [1]	826,000	
Unsubstantiated Reports of Child Abuse & Neglect Receiving Services [1]	217,000	
Cost of Each Investigation* [2]	$990	
Cost of Service Per case* [2]	$3,295	
Total Cost of Investigations and Services [3]		*(A)* $5.215 billion
Total Spending on Investigations and Services** [3]		*(B)* $2.652 billion
Spending Gap		*(A-B)* **$2.563 billion**

1. U.S. Department of Health & Human Services (2001). *Child Maltreatment 1999.* Washington, DC. U.S. Government Printing Office.
2. Courtney, M.E. (1998). *"The Costs of Child Protection in the Context of Welfare Reform".* The Future of Children, Vol. 8, No. 1.
3. Bess, R. (2001). *The Cost of Protecting Vulnerable Children II: What Has Changed since 1996?.* Washington, DC. Urban Institute.

* 1993 dollars adjusted for inflation to 2001

** Includes spending on prevention

Committee on Education and the Workforce
Witness Disclosure Requirement – "Truth in Testimony"
Required by House rule XI, Clause 2(g)

Your Name: Charles Wilson, MSSW

	Yes	No
1. Will you be representing a federal, State, or local government entity? (If the answer is yes, please contact the Committee).		X

2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October, 1, 1998:

As Director of the Center for Child Protection (CCP) at Children's Hospital and Health Center in San Diego, California since August 2000

- CCP receives no direct federal grants.
- CCP does receive federal funds flowing through state agencies for victim's compensation, medical services, and medical related services. We also receive a $10,000 grant from the National Children's Alliance that originates from the OJJDP in the Department of Justice.
- CCP has a contract with the US Navy to train 76 Family Advocacy and Criminal Investigative personnel in investigation and treatment of child abuse at the annual San Diego Conference on Child and Family Maltreatment-$32,000

As Director of the National Children's Advocacy Center (NCAC) in Huntsville, Alabama from 1995-2000, we received several grants from OJJDP/DOJ

- The Southern Regional Children's Advocacy Center cooperative agreement-$425,000
- The Safe Kids/Safe Streets grant $800,000
- A grant of $17,000 to support the National Symposium on Child Sexual Abuse
- A $10,000 grant from the National Children's Alliance.
- HUD related capital grant $925,000
- HUD related capital grant $250,000
- Like CCP, the NCAC receives support from the State for therapy that originates as federal funds.

	Yes	No
3. Will you be representing an entity other than a government entity?		X

4. Other than yourself, please list what entity or entities you will be representing:
The National Child Abuse Coalition, which is a non-incorporated coalition of organizations interested in preventing and responding to child abuse.

5. Please list any offices or elected positions held and/or briefly describe your representational capacity with each of the entities you listed in response to question 4:
I serve as a member of the Coalition, representing the National Call to Action, which is an unprecedented coalition of 30 national organizations working together to implement a 20-year action plan to drastically reduce the prevalence of abuse over the next 20 years.

6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1998, including the source and amount of each grant or contract:
The Child Abuse Coalition does not receive any federal grants.

	Yes	No
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing? If so, please list:		X

Signature: _____ Date: 7/30/01

Please attach this sheet to your written testimony.

APPENDIX F – WRITTEN STATEMENT OF MS. DEBORAH STRONG, EXECUTIVE DIRECTOR, PREVENT CHILD ABUSE MICHIGAN, ON BEHALF OF PREVENT CHILD ABUSE AMERICA, CHICAGO, ILLINOIS

TESTIMONY
for

The Subcommittee on Select Education
of the
Committee on Education and the Workforce
U. S. House of Representatives

Hearing on the
Child Abuse Prevention and Treatment Act

August 2, 2001

Room 2175, Rayburn Building

Presented by:

Deborah Strong, Executive Director
Prevent Child Abuse Michigan

on behalf of

Prevent Child Abuse America
200 South Michigan Avenue
Chicago, IL 60604

Contact: *Michelle Rieff, Prevent Child Abuse America, 312-663-3520, mrieff@preventchildabuse.org*
Deborah Strong, Prevent Child Abuse Michigan and Michigan Children's Trust Fund, 517-373-4320, strongd@state.mi.us

Good morning Chairman Hoekstra, Congressman Roemer, and members of the House Education and the Workforce Subcommittee on Select Education. Thank you for holding this hearing on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). I would like to add a special thanks to you, Mr. Chairman, for your work back home in Michigan on behalf of children and for your leadership in reauthorizing CAPTA. In addition, I would like to extend a special thanks to you, Congressman Roemer, for inviting Prevent Child Abuse America to testify this morning.

My name is Deborah Strong and I am the director of the Michigan Children's Trust Fund/the Michigan Chapter of Prevent Child Abuse America. We are the only statewide, non-profit organization dedicated solely to the prevention of child abuse and neglect. We do this through public awareness, education, training and technical assistance, and the funding of a statewide network of community-based prevention programs. We are also the designated State Lead Agency in Michigan for the Community Based Family Resource and Support Grant (Title II of CAPTA). With the support of CAPTA, this past year, we were able to provide prevention services to 81 of Michigan's 83 counties and positively touch the lives of more than 750,000 children and families.

I am honored to be here today to speak on behalf of Prevent Child Abuse America, the leading national organization working at the local, state, and national levels to prevent child abuse and neglect of our nation's children. For nearly 30 years, Prevent Child Abuse America has led the way in building awareness of, providing education on, and developing and disseminating proven and effective tools for preventing child abuse and neglect. Working with 39 chapters in 38 states and the District of Columbia, we represent a vast network of children and families, family support workers, and volunteers – all dedicated to serving as a resource to individuals who seek support in their role as parents and caregivers.

I am also honored to be here today to highlight the great work that is being done by so many other organizations to prevent the abuse and neglect of children throughout our nation's communities.

Responding to child abuse and neglect demands a national perspective and response. Since 1974, CAPTA has been part of the federal government's effort to help states and communities improve their practices in preventing and treating child abuse and neglect.

Preventing child abuse and neglect has become an increasingly daunting – yet essential – undertaking. According to a report conducted by Prevent Child Abuse America, the number of children reported as abused or neglected in the United States from 1990-99 grew by 33 percent to nearly 3.3 million children. In 1999, the number of confirmed cases of child maltreatment was just over 1 million. Tragically, nearly 4 children die each day from child abuse and neglect and, equally as devastating, near-fatal child maltreatment leaves 18,000 children permanently disabled each year.

In Michigan, more than 350 cases of child abuse and neglect are reported each day; even more go unreported. Over two thirds of these reported victims involve our most vulnerable populations: young children ages six and under. Further, 85% of the abuse and neglect is committed by a family member and most could have been prevented. Child abuse is colorblind and crosses all boundaries. It is not restricted by race/ethnicity, socio-economics, gender, or

geography. The next time you are in a school, at church, on a playground or at a children's event, think about the fact that one out of every five children you see will be a victim of child abuse or neglect before they turn 18.

Despite the epidemic proportions in the number of children who are reported as abused and neglected each year -- many of whom acquire disabilities or even die from such maltreatment -- funding for these programs has failed to keep pace with the scope of the problem. As a result, our nation is forced to continually increase spending on the devastating consequences of child maltreatment, including out-of-home placements, juvenile delinquency, adult crime, substance abuse, mental illness, unwanted teenage pregnancy, special education and other disability services, and the list of financial and human costs goes on and on.

Such costs to individual children and families and our nation as a whole are unconscionable, particularly when, so often, they can be prevented. Even more devastating is that these costs to society and individuals will continue, as long as prevention programs remain grossly overlooked and under funded.

Community-based child abuse prevention efforts supported by Title II of CAPTA, such as respite care, home visiting, parent mutual support, parent education, and family resource services, warrant an increase in attention and funding. The need is much greater than the resources allocated for many of these programs.

CAPTA also enables communities to coordinate and support local networks of prevention services. Even a model program with wonderfully trained staff can fail if parents are unaware of it's existence or how to access it due to lack of transportation, service coordination, referrals, outreach and support.

Until we can develop a critical mass of prevention programs and services throughout the states, we will never be able to make a significant impact on the number of children coming into the child protective system (CPS) system every year and prevention will remain the last frontier in the continuum of services for children and families.

As President Bush noted in his Proclamation designating April as Child Abuse Awareness Month:

> *"Prevention remains the best defense for our children. State Community-Based Family Resource and Support Programs sponsor activities promoting public awareness about child abuse and information on how to stop it."*

Prevention is also a strong investment for our economy. In April, Prevent Child Abuse America released a landmark study, which looked at the cost our country incurs every year as a direct or indirect result of child abuse and neglect. We discovered that today – and every other day this year – child abuse and neglect will cost the American taxpayer $258 million, which is more than $94 billion annually. Put another way, the consequences of child abuse and neglect costs every American family more than $1,400 each year.

While each American family pays more than $1,400 per year as a result of child abuse and neglect, families only pay the equivalent of $1.06 for programs aimed at prevention. Currently,

primary prevention programs – that is, programs that prevent child abuse and neglect before they ever occur – are funded at $32.8 million, compared to at least $6 billion for intervention, treatment, and out-of-home placements.

Prevent Child Abuse America does not mean to imply that the costs of services for treatment and intervention are too high or that the services themselves are not essential; but, there is a tremendous imbalance between what is invested on the front end to *prevent* abuse and neglect before it happens and what is spent as a consequence *after* abuse or neglect has occurred and out-of-home placement is needed.

For us, prevention means more than preventing out-of-home placements – it means stopping abuse and neglect before it ever occurs.

To echo the words spoken by Majority Whip Tom DeLay on the House Floor in recognition of April as Child Abuse Prevention Month: "It is [our] hope that the facts and consequences of abuse and neglect will create a national consensus that underscores the importance of prevention…Prevention is worth the risk."

While other federal programs, such as the Promoting Safe and Stable Families program, allow funds to be used for prevention purposes on the state level, these funds all too often are used for what might more accurately be described as *tertiary* prevention – that is, responding once a child is already known to the child welfare system, not necessarily working with families to keep the them from ever getting to that point.

Title II represents the only source of federally dedicated funding for primary prevention, enabling families to get the support they seek *before* they come to the attention of the Child Protective Services system.

As long as prevention remains a marginal component of the child welfare system, children who suffer substantiated abuse and neglect will continue to be neglected by the very system designed to protect them. Currently, less than half of child victims of abuse and neglect receive services.

By supporting language in the reauthorization of CAPTA that targets child abuse and neglect prevention, the Subcommittee on Select Education can help enable communities to fulfill their vital role in providing services and support to the thousands of children and families who seek out local resources to support them in their roles as parents and community leaders, while also mitigating the risk of child abuse and neglect.

Title II Community-Based Family Resource and Support Programs (CBFRS) are showing positive outcomes. Prevention programs such as respite care, home visiting, parent mutual support, parent education, and other family resource services are making a difference in the lives of children and families.

In Michigan, one of the programs we fund is Healthy Start Oakland. With private foundation money, Dr. Cynthia Shellenbach of Oakland University conducted a five-year longitudinal/ control group study that produced startling results. Outcomes for the 322 families involved include:

- Only 1.5% of families utilizing the Healthy Start program had substantiated reports of child abuse and neglect as compared to 14% for the control group.
- The Healthy Start families scored significantly higher on child development outcomes as compared to the control group
- As many as 95% of the children enrolled in the Healthy Start program were fully immunized as compared to 85% of families in the control group.
- Use of the emergency room was much lower among Healthy Start participants (6.2%) as compared to the control group (42%), which represents a significant cost-savings to the community in health care costs. As emergency room use declined, use of physician visits related preventive care and illnesses increased.

In Indiana, 100% of participants who provided feedback on a parent mentoring service offered through a program called, "Youth Mother's Education Development," were highly satisfied with the availability of services and information about parenting, which illustrates how CBFRS programs are effective in engaging parents -- one of the primary measures of success, since these family support programs are all voluntary.

Successes in changed attitudes and behavior have also been documented by CBFRS programs nationwide. In Pennsylvania, a CBFRS program called the Family Center reported that 91% of parents surveyed indicated that the program had always or usually helped them take better care of their children and families; 86% indicated that it had helped them gain control of their life; and 85% reported that it had helped them have a greater sense of hope for their personal growth.

Strengthening the prevention focus of and funding for CAPTA, with particular attention paid to Title II, would help local communities prevent abuse and neglect from happening in the first place. Prevent Child Abuse America has been working closely with the National Child Abuse Coalition to strengthen federal language for Title II to focus more on core family support and community-based child abuse and neglect prevention programs, including respite care, home visiting, parent mutual support, parent education, and family resource services.

Our request is threefold:

1. **We request your consideration and support of the Title II CBFRS language that will be put forward by the National Child Abuse Coalition, which focuses on core community-based child abuse and neglect prevention programs, including respite care, home visiting, parent mutual support, parent education, and family resource services.**

2. **We request that you urge your colleagues on the House Appropriations Committee to increase Fiscal Year 2002 funding for Title II to its current fully authorized level of $66 million (as the National Child Abuse Coalition is recommending).**

3. **We urge you to set a higher authorization level for CAPTA. Specifically, we are asking you to reauthorize Title II at $500 million (as the National Child Abuse Coalition is recommending).**

As President Bush proclaimed in April, prevention truly is the best defense for our nation's children. If we continue to ignore this truth, the price tag of child abuse and neglect will continue to grow along with the suffering of our nation's children.

We cannot afford to let this happen.

Re-authorizing CAPTA with Title II provisions that warrant and *receive* increased funding would provide families in communities across the country with what they are seeking – the support they need to strengthen their families and avoid a very costly and tragic cycle of abuse and neglect.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: DEBORAH STRONG

	Yes	No
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).		✓

2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1998:

CBFRS GRANT / TITLE II OF CAPTA

	Yes	No
3. Will you be representing an entity other than a government entity?	✓	

4. Other than yourself, please list what entity or entities you will be representing:

PCA/AMERICA

5. Please list any offices or elected positions held and/or briefly describe your representational capacity with each of the entities you listed in response to question 4:

NO ELECTED OR APPOINTED OFFICES HELD — THE MICHIGAN CHILDREN'S TRUST FUND IS ALSO THE MICHIGAN CHAPTER OF PCA/AMERICA

6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1998, including the source and amount of each grant or contract: YES / OCAN

PCA/AMERICA RECEIVES A GRANT TO GROW PARENT MUTUAL SUPPORTS IN UNDERSERVED AREAS. GRANT IS $500,000 OVER 2 YEAR PERIOD IN PARTNERSHIP WITH THE NATIONAL FAMILY SUPPORT ROUND TABLE

	Yes	No
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing? If so, please list: TO THE BEST OF MY KNOWLEDGE, NO		✓

Signature: Deborah Strong Date: August 1, 2001

Please attach this sheet to your written testimony.

APPENDIX G – SUBMITTED FOR THE RECORD, BY JUSTICE FOR CHILDREN, ARTICLES: "CAPTA RE-AUTHORIZATION ISSUE: EXPANDING LAW ENFORCEMENT'S ROLE IN CHILD ABUSE INVESTIGATIONS"; "CAPTA RE-AUTHORIZATION ISSUE: REQUIRING "OPEN COURTS" IN JUVENILE DEPENDENCY HEARINGS": AND "CAPTA RE-AUTHORIZATION ISSUE: ELIMINATING RELIGIOUS EXEMPTIONS FOR MEDICAL TREATMENT".

CAPTA RE-AUTHORIZATION ISSUE: EXPANDING LAW ENFORCEMENT'S ROLE IN CHILD ABUSE INVESTIGATIONS

Kimberly Randall, JFC Law Student Extern
and Randy Burton, President, Justice for Children

Over the last two or three decades a shift has emerged in how policy makers and professionals in the child abuse field view the social character of child abuse. Assaults on children are no longer just a social welfare problem; they are now considered a crime.[1] Reflecting this emerging paradigm, there has been an increasing involvement of the police in child abuse investigations. Multi-disciplinary response teams and children's advocacy centers are being implemented across the country, and in some states such as Florida and Arkansas, the role of law enforcement is being expanded and the police are sometimes taking the lead in child abuse investigations.[2] Justice for Children (JFC) believes that law enforcement's role is critical if states are to combat effectively all forms of child maltreatment. For the reasons set out below, JFC proposes that CAPTA require state law enforcement personnel to take the lead in investigating all reports of serious child abuse and neglect.

1. Law Enforcement's Superior Training in Investigative Techniques, Ability to Obtain Search Warrants, and Socially Recognized Position of Authority Improves the Probability that Perpetrators of Child Abuse Will Be Indicted -- While Sparing Child Victims the Trauma of a Criminal Trial.

The primary objective of child abuse investigators should be to build as strong a case as possible.[3] Strong cases encourage defendants to accept plea bargains and often eliminate the need for child victims to testify in criminal trials. However, allegations of child abuse may be very difficult to prove beyond a reasonable doubt because the cases lack third-party witnesses, physical evidence, or a victim old enough to be a credible witness.[4] Accordingly, the employment by law enforcement officers of investigative crime-scene procedures may play a critical role in building a strong case. Placing the police in the lead of child abuse investigations permits them to make the initial investigative decisions and avoid, for example, mistakes made by child protection workers who may unwittingly tamper with or destroy physical evidence.[5] Law enforcement priorities focus on effective prosecution and protection of its complaining witness (in child abuse cases, naturally, the child), unfettered by CPS's mandate to preserve the family unit. Moreover, unlike police officers, child protection workers cannot obtain search warrants or employ techniques such as monitoring "pretext conversations" between a victim or family member and a suspect.[6] Nor can they make arrests even when probably cause exists. In sum, law enforcement personnel possess better investigative methods and tools than child protective services workers. These advantages should positively affect case outcomes and increase the state's ability to protect children.

Additionally, a 1994 empirical study conducted by the Denver, Colorado-based Center for Policy Research reported that where police officers attended interviews with child victims and suspects, investigations were "significantly more likely to result in perpetrator confessions and victim corroborations."[7] The researchers concluded that the law enforcement officer's presence served to apply pressure on suspects to cooperate with the investigation or face arrest.[8] Perpetrator confessions and victim corroborations help in building strong cases, and protect children from further abuse as well as the trauma of testifying in court.

When a proper investigation by a trained professional is not performed, evidence is lost or not collected altogether. As a result, the evidence needed to both successfully prosecute the perpetrator of the abuse and to remove the child from the abusive environment does not exist. This invariably results in the child being left in the home with the offender, a situation arguably made more dangerous by the failure of the investigation.

In summary, based upon our own empirical data and experience, the anecdotal data of other jurisdictions and child advocates, and the commentary of several leading researchers, Justice for Children believes that law enforcement must have the lead role in the investigation of children for the following reasons: (1) Child abuse is by definition a crime; (2) Law enforcement has the exclusive authority as a matter of law to investigate all criminal activity; (3) Law enforcement alone has the training and experience to gather the necessary evidence to make a criminal case; (4) Law enforcement's priorities are the proper investigation of criminal cases, bringing offenders to the bar of justice, and protection of their complaining witness; (5) law enforcement is unfettered by the objective of family preservation in pursuit of their investigation; (6) CPS role is to conduct a *civil* investigation into allegations of abuse or neglect and determine whether the child should be removed from the home; (7) CPS preferred objective in every civil investigation is to keep the family unit together; (8) Both law enforcement and CPS have equal authority to make an emergency removal of any child that they believe to be in danger and to place the child in protective custody; (9) Much of the physical evidence in child abuse cases is evanescent and time is of the essence in these investigations. Accordingly, we believe that it is self-evident that law enforcement's criminal investigation of child abuse should take priority over all others. Placing law enforcement at the beginning of the investigation and allowing it to lead the process will remedy errors made at intake involving the prioritization, investigation, and referral of cases by CPS and will eliminate counterproductive complexity and ambiguity in the roles of the agencies involved in the child's case.

2. **Putting Law Enforcement in the Lead of Child Abuse Investigations Will Decrease Problems Stemming from Child Protective Services' Dual Role in Child Welfare. Moreover, Where Multidisciplinary Teams Are Used, the Lead Role of Law Enforcement Will Reduce the Likelihood that Philosophical Conflicts Between Child Protective Services and Law Enforcement Will Detrimentally Impact a Child Abuse Investigation.**

Child protective service (CPS) caseworkers are charged with a dual role in addressing child abuse and neglect case, and state law mandates this role in most jurisdictions.[9] CPS workers are not only responsible for protecting children from further abuse and neglect, but also must make all reasonable efforts to preserve the biological family.[10] In 1997, the Arkansas legislature addressed the child protective services worker's conflicting role and transferred certain responsibilities for child abuse investigations to the state police. "The reasons cited for the transfer were the need to separate the dual roles of investigator and service provider, the compromise of investigations that arises as a result of this dual role, and the need for investigators with special expertise in crimes against children and related domestic abuse."[11]

In jurisdictions that use a multidisciplinary team approach, the problem of conflicting roles continues to cause disagreements in child abuse investigations, generally, and competition among team members in evaluating cases, specifically.[12] Consistent with the belief that child abuse is an illness and that families (even criminally dysfunctional ones) should be preserved, child protective caseworkers typically hold a pro-therapeutic perspective in addressing child abuse and neglect. On the other hand, police are charged with obtaining the facts of a case, determining whether a crime has been committed, and taking appropriate action against the perpetrator. By placing law enforcement in the lead of child abuse investigations, many of these conflicts will tend to recede and cause fewer problems in investigating child abuse. Under this model, police will be able to control the initial investigation, decide whether a crime has been committed, and then take appropriate action. Subsequently, child protective workers can offer social or other services to the family if these services are deemed necessary.

3. By Placing All Forms of Child Maltreatment Within the Domain of Law Enforcement and Criminal Justice, Physical Abuse and Neglect of Children May Be More Effectively Addressed in Society Generally.

Traditionally, child welfare agencies have been charged with the responsibility of receiving child abuse/neglect reports and investigating allegations. With the increasing publicity and public abhorrence of child sex abuse, this area of child maltreatment has seen an increase, over other areas, of police involvement and the filing of criminal charges. For example, beginning in 1987, all child sex abuses reports in Dupage County Illinois were referred to the Children's Sexual Abuse Center for investigation. The Center's staff takes a pro-prosecution approach to child sex abuse cases, and believes that criminal prosecution is necessary to force offenders into treatment and maintain criminal records substantiating any patterns of behavior.[13] Moreover, in another study of 1,828 suspected child abuse reports gathered from five different states by the Colorado-based Center for Policy Research, the police were involved in 75% of the sex abuse cases but in only 49% of the serious physical abuse cases.[14] Additionally, according to an analysis in a U.S. Department of Justice publication, "[n]eglect accounts for a large proportion of child maltreatment cases, but is often not considered criminal in nature and frequently may not be reported to law enforcement." [15]

Physical abuse and neglect represent serious threats to children's psychological development and physical safety. These types of maltreatment are also responsible for child fatalities across the United States. JFC supports the position that more aggressive arrest and prosecution of caretakers who physically assault their children raises awareness about the problem, reinforces norms of conduct, reduces recidivism, and empowers victims.[16] Similarly, placing the serious neglect of children into the domain of the criminal justice system will significantly reduce this form of maltreatment, especially by those parents whose neglect of their children stems from drug addiction or involvement in other criminal activities. These parents might, for example, benefit from the DuPage County model: that is, be forced into treatment programs to address the underlying reasons causing them to physically abuse or neglect their children.

This approach does not deny the legitimate role that CPS fulfills in the protection of children but properly, indeed, critically, reorients the focus of the investigation by placing law enforcement at the forefront of the investigation of crimes against children, instead of CPS.

In conclusion, placing law enforcement in the lead of all child maltreatment cases will increase public awareness of this phenomena, criminalize all forms of serious child abuse and neglect, and, consequently, serve to increase the protection of children at risk.

4. **The DC Problem: The District of Columbia Has Placed the Primary Responsibility for the Investigation of Physical and Sexual Child Abuse with the Metropolitan Police Department. Unfortunately, Due to Poor Management and Lack of Resources, DC Legislators Are Now Considering a Change to "Co-Leadership" that would be Shared by the Police and the DC Children and Family Services Agency (CFSA).**

As early as 1977, according to my research, the District of Columbia recognized the benefits of placing the responsibility for child abuse investigations with the police. At that time, the Metropolitan Police Department was charged with investigating all cases of physical child maltreatment. The police developed two special units, one for sexual abuse cases and another for physical abuse cases; in 1999, these entities were merged into one child abuse unit. During this time period, the DC Children and Family Services Agency (CFSA) has been responsible for investigating all reports of child neglect. In spite of these directed efforts to improve the District of Columbia's ability to protect its children, DC's child abuse protection system as a whole has suffered from lack of resources and poor management.

Captain Enzalo, the Deputy Director of the DC Police Department's Child Abuse Unit, reports that the District of Columbia is considering changing its current child abuse and neglect investigative system to a "co-lead" on physical abuse cases that would be equally shared by the police and the CFSA.[17] Captain Enzalo cites three factors underlying the proposed change: the lack of police department resources; poor case screening at the CFSA-operated hotline; and the police child abuse unit's case overload. In the first six months of 2001, the police department's child abuse unit received 1600

cases for investigation -- to be pursued by a detective staff of only thirty-five. According to Captain Enzalo, moreover, the CFSA hotline refers cases to the police department without proper screening. Vital man-hours and resources are being expended on investigating reports of spanking. In addition, the officers working for the child abuse unit complain of lack of training, lack of expertise among current staff due to the promotion system within the police department, and the absence of a centralized computer system to log and track the existing cases.[18]

Even though CFSA is reported to have more resources than the police department, the former agency suffers from a detrimentally high turnover rate among caseworkers and the effects of burnout among many of those remaining.[19] JFC believes that changing the physical/sexual child abuse investigative system to a co-lead between the police and CFSA may not solve the existing problems and may further prevent the District of Columbia from effectively protecting its children at risk. Further debate and recommendations are forthcoming from Ward 3 DC Council member Kathy Patterson (who recently held a public hearing on these issues).[20] JFC hopes more effective solutions will be proposed and implemented.

[1] This proposition has been recognized by advocacy organizations even on the opposite side of the ideological spectrum. *See, e.g.,* Susan Orr, *Child Protection at the Crossroads: Child Abuse, Child Protection, and Recommendations for Reform*, Policy Study No. 262, Reason Public Policy Institute, October 1999. (The Reason Public Policy Institute [RPPI] supports a lead role for law enforcement in child abuse investigations and the criminalization of child abuse. JFC, however, presumably does not support most other RPPI positions, such as calling for a reduced role for government in addressing child abuse).
[2] David Finkelhor and Richard Ormrod, *Child Abuse Reported to the Police*, U.S. Department of Justice, Juvenile Justice Bulletin, May 2001 (specifically citing Florida as an example where, in four counties, the sheriff's offices have been given the responsibility for child abuse investigations). **NOTE:** A research study of child abuse investigations in these four Florida counties is currently being conducted under the direction of Professor Richard Gelles of the University of Pennsylvania. Although Professor Gelles has not yet publicly released any of his preliminary data, his research director suggested in an e-mail to Kimberly Randall that the research group might be willing to release some of the data to JFC staff if JFC were to make a formal and detailed request.
[3] Donna Pence and Charles Wilson, *The Role of Law Enforcement in the Response to Child Abuse and Neglect,* Washington, D.C.: National Center on Child Abuse and Neglect , 1992, at 25.
[4] Patricia Tjaden and Jean Anhalt, *The Impact of Join Law Enforcment-Child Protective Services Investigations in Child Maltreatment Cases*, Center for Policy Research, Denver, CO., September 1994, at 83.
[5] Pence and Wilson, *supra*, note 2 at 10.
[6] Id. at 59.
[7] Tjaden and Anhalt, *supra*, note 5 at 86.
[8] Id.
[9] Pence and Wilson, *supra*, note 2 at 9.
[10] Id.
[11] *See Child Abuse Investigations Transferred to State Police*, Youth Law Review 9, May-June 1998.
[12] Pence and Wilson, *supra*, note 2; *see also*, Tjaden and Anhalt, *supra*, note 3 at 91.
[13] Tjaden and Anhalt, *supra*, note 3 at 11.
[14] Id. at 36.
[15] Finkelhor and Ormrod, *supra*, note 1 at 2.
[16] Id. at 7.
[17] Telephone Interview with Captain Enzalo, Deputy Director of the Child Abuse Unit, District of Columbia Metropolitan Police Department (June 22, 2001).

[18] *Public Oversight Hearing on the Investigation of Child Abuse and Neglect and Child Fatalities, June 28, 2001 before the Committee on the Judiciary, Council of the District of Columbia* (statement of Thurman Hampton, Interim Director, Safe Shores: The DC Children's Advocacy Center).
[19] Telephone interview with Captain Enzalo, *supra*, note 17.
[20] *Public Oversight Hearing on the Investigation of Child Abuse and Neglect and Child Fatalities, June 28, 2001 before the Committee on the Judiciary.* (Councilmember Kathy Patterson, Chairperson, Committee on the Judiciary, *The Investigation of Child Abuse and Neglect and Child Fatalities.*) **NOTE:** A report of findings and recommendations will be issued at a later date.

CAPTA RE-AUTHORIZATION ISSUE: REQUIRING "OPEN COURTS" IN JUVENILE DEPENDENCY HEARINGS

Kimberly Randall, JFC Law Student Extern
and Randy Burton, Justice for Children

Justice for Children (JFC) believes that a policy of "open courts" in child dependency proceedings is crucial to reforming and improving the delivery of services to children under the care of the state, and to the formulation of decisions regarding these children's futures. The Child Abuse, Prevention and Treatment Act (CAPTA) is currently silent on the issue of open courts. JFC proposes that amendments to CAPTA include provisions supporting the opening of dependency proceedings in states receiving funds under CAPTA.

JFC provides the following arguments in support of its position:

1. **Public Scrutiny Will Enable Parties in the Dependency System to Be Held Accountable for Their Actions, Improve Procedural Regularity in Dependency Proceedings, and Provide Opportunities for Reform.**

The juvenile court system, by its very nature, is informal and not subject to the rigorous procedural rules applied in adult courts. Additionally, juvenile court judges have significant powers of discretion in deciding cases. As early as 1967, the U.S. Supreme Court began to recognize such deficiencies with respect to the juvenile courts. It noted the "[f]ailure to observe the fundamental requirements of due process" creates "unfairness to individuals and inadequate or inaccurate findings of facts and unfortunate prescriptions of remedy."[1] Public access would force a greater level of procedural regularity in juvenile courts, permit the public to hold courts accountable for inconsistent application of rules, and reduce flaws in fact finding. New York State took this position in 1997, after the tragic and preventable death of a six-year-old female child under its care; the child had been battered and sexually abused. Extended family members reported serious errors in how caseworkers and the juvenile court handled her case.[2] The legislature responded by adopting presumptively open courts in dependency proceedings.

Open courts provide an opportunity for members of the public to critique flaws in the system, become educated about the child welfare proceedings, initiate informed research and, ultimately stimulate reform where needed.

2. **Open Courts Will Improve the Protection of Children and Can Still Be Sensitive to Important Privacy Issues.**

One of the greatest criticisms of open dependency hearings is that public access will violate children's right to privacy and jeopardize their psychological and physical safety. To date there is no empirical evidence indicating that children are traumatized by the presence of an audience while giving testimony.[3] Legal scholars and other children's

advocates argue, moreover, that legislation creating "presumptively open" courts can also allow for judicial discretion to close the proceedings if the trial judge finds that publicity may be harmful to the child.[4]

In Globe Newspaper Co. v. Superior Court, 457 U.S. 596 (1982), the U.S. Supreme Court struck down a Massachusetts statute requiring closure of the court during the testimony of minors in sex-offense trials. The Court ruled that minors can only be protected by a case-by-case analysis, and that a blanket closure requirement was unconstitutional.[5] The Appellate Division of the New York Supreme Court, in In re Katherine B., 189 A.D. 2d. 443 (N.Y. App. Div. 1993), suggested several factors for consideration in weighing a decision to close a proceeding: the nature of the abuse allegations (with sexual abuse allegations weighing heavily against closure); the child's age and maturity level; peer pressure from classmates in school; and the potential for embarrassment.[6]

In sum, "presumptively open" proceedings permitting public access in all cases -- except those with a standardized finding of necessity for closure -- provide one way of ensuring that the child protection system works as effectively as possible in protecting children's interests. To eliminate any concern over potential delays in proceedings, state statutes can provide that motions for closing a hearing be considered as soon as they are made.

3. Open Courts Will Improve the Fairness of Dependency Proceedings to Respondents and Need Not Delay Placement of the Child.

Critics argue that open courts will delay final placement of a child because parents who are subject to public pressures and/or able to garner support from the public will more frequently contest cases. Closed courts, by contrast, often permit the state to exert formidable pressures on parents to make some admissions of guilt before it will allow parents to be reunited with their children. In some cases, in fact, admissions of guilt have been required to obtain social services for reunifying the family.[7]

But if respondents sincerely need or wish to contest the charges against them, open court proceedings will improve the ultimate fairness of the proceedings to the family. Morever, the unfortunate fact that many parents do not have a genuinely enduring interest in the disposition of their child diminishes the argument that open courts will delay placement of the child. (Parents who, by contrast, have a genuine interest in raising or being involved with their child can request that their case be channeled into alternative dispute resolution procedures that are more private, such as mediation or family conferencing.)

4. Historically, Dependency Hearings Were Open to the Public.

The procedures often employed in state dependency hearings in the U.S. originated in the historical procedures for guardianship found in the English courts of Chancery and Law. In England, the Chancery Courts traditionally acted as dependency courts do today

in the U.S.; they had jurisdiction over displaced, abused or neglected children, administered the provision of a guardian, and otherwise acted to assure the children's safety. These Chancery proceedings were conducted in open court. Moreover, cases involving babies in need of protection, which in the eighteenth century came under the jurisdiction of the English Law Courts, were also heard in public.[8]

The commonly held belief in the U.S., that our juvenile courts since their inception in 1899 have always been closed, is not entirely supported by the facts, either. A survey of American juvenile courts in the 1960's describes a juvenile courtroom "as full of the covert turmoil created by the bustle of staff, witnesses, and guests of the court as any adult court."[9] In addition, the survey notes, "... the exceptions made in the case of persons or agencies deemed to have a legitimate need to inspect are so numerous as to seem as much the rule as the exception."[10]

There is an expanding trend toward open hearings.[11] Currently, state practice in ten jurisdictions presume courts to be open with judicial discretion to close; the state of Oregon requires open proceedings in all dependency cases.[12] An additional twelve jurisdictions have presumably closed proceedings, but permit judicial discretion to open them.[13] A California Appellate Court, in considering the press's access to a dependency proceeding, declared in a 1991 ruling its "support of the proposition that the states should remain free to continue their exploration for a system best suited for addressing the problems of our youth."[14] JFC believes CAPTA should be amended to encourage states to open their dependency proceedings as a matter of uniform procedure and accountability.

5. Open Hearings Do Not Necessarily Violate the Record Confidentiality Provisions of CAPTA or Title IV-E of the Social Security Act.

Opponents argue that permitting open hearings will expose members of the public to the contents of children's records, thereby violating the confidentiality requirements under both CAPTA and the Social Security Act. Typically, the contents of records are not read in court and any portions of the records that may need to be included in court discussions may be managed in such a way as to protect the privacy rights of the child. Pertinent portions may be discussed in chambers, the judge may temporarily clear the court room for sensitive testimony relating to these records, and the judge may make special arrangements with members of the press restricting their ability to publish the identities of the parties and witness. Both the Conference of Chief Justices and the Conference of State Court Administrators support open court hearings and recommend that CAPTA be revised to permit the states individually to address the issues of open courts and methods for maintaining record confidentiality.[15]

6. The Public Has Fiscal and Civic Interests in Being Able to Attend Dependency Proceedings.

The petitioner in dependency proceedings is typically the local child protective services agency, which works in tandem with the local county counsel. Dependency

courts, the agencies involved in the disposition of children coming into the court system, and related social programs are all funded by state and federal taxpayers. Judges are frequently elected officials. Cumulatively, then the public has a significant interest in knowing how its tax dollars are being used, and has a right to observe and evaluate the performance of its elected officials.

[1] In re Gault, 387 U.S. 1, 19-20 (1967).
[2] *Girl's Death*, N.Y. Times, Nov. 29, 1995, at B8.
[3] Debra Whitcomb et al., U.S. Dep't of Justice, *When the Victim is a Child: Issues for Judges and Prosecutors* 46 (1985).
[4] *See* Mary McDevitt Gofen, *The Right to Child Custody and Dependency Cases*, 62 U. Chi. L. Rev. 857 (1995); San Bernardino v. Sun Newspaper, 232 Cal. App. 3d 188 (Cal. Ct. App. 1991).
[5] Globe Newspaper Co. v. Superior Court, 457 U.S. 596, 608-609 (1982).
[6] Emily Bazelon, *Public Access to Juvenile and Family Court: Should the Courtroom Doors be Open or Closed?* 18 Yale L. & Pol'y Rev. 155, 162-63 (1999) (citing In re Katherine B., 189 A.D. 2d 443 (N.Y. App. Div. 1993); *See also*, San Bernardino, 232 Cal. App. 3d 188.
[7] *See, e.g.* In re Jessica B., 254 Cal. Rptr. 883 (Cal. Ct. App. 1989) (the court refused to order reunification services until the father admitted abusing his infant daughter).
[8] Samuel Broderick Sokol, *Trying Dependency Cases in Public: A First Amendment Inquiry*, 45 UCLA L. Rev. 881, 905-908 (1998).
[9] *See* Orman W. Ketcham, *The Unfulfilled Promise of the American Juvenile Court*, in Justice for the Child 31 (Margaret K. Resenheim ed., 1962)
[10] Id. at 29.
[11] Sokol, *supra* note 8, at 911.
[12] Kay Farley, *The Washington Review*, 14 The Court Manager 39 (1999) (the ten jurisdictions are Florida, Indiana, Iowa, Maryland, Minnesota, Nebraska, New York, North Carolina, Northern Mariana Islands, and Texas). **NOTE: We are awaiting final confirmation from Kay Farley that this information is still accurate and that we have correctly interpreted the categories she created.**
[13] Id. (The twelve jurisdictions are Alabama, Arizona, Colorado, Connecticut, Maine, Michigan, Missouri, Oklahoma, South Dakota, Tennessee, Virgin Islands and Wisconsin.) **NOTE: We are awaiting final confirmation from Kay Farley that this information is still accurate and that we have correctly interpreted the categories she created.**
[14] San Bernardino, 232 Cal. App. 3d at 343.
[15] Telephone Interview with Kay Farley, Staff Member, National Association for Court Management (June 13, 2001).

CAPTA RE-AUTHORIZATION ISSUE: ELIMINATING RELIGIOUS EXEMPTIONS FOR MEDICAL TREATMENT

Kimberly Randall, JFC Law Student Extern
and Randy Burton, President, Justice for Children

The Child Abuse, Prevention and Treatment Act (CAPTA) explicitly states in 42 USC §5106i(a)(1) that the federal government does not require a parent or legal guardian to provide medically necessary treatment to sick children if it is contrary to the parent's/guardian's religious beliefs. Furthermore, subsection (2) indicates that the federal government does not require a state to find abuse or neglect in cases where a parent or legal guardian relies solely on spiritual means of healing in accordance with religious beliefs. The statutory language effectively results in impunity for those parents practicing faith-healing religions who cause their children to suffer serious harm -- or even death -- from preventable physical ailments. Currently, thirty-six states plus the District of Columbia have religious exemptions in their civil child abuse and neglect statutes and thirty-one states have one or more religious exemptions in their criminal codes.[1] Justice for Children (JFC) believes that CAPTA's religious exemption should be repealed. In order for states to receive CAPTA funds, state laws should require all parents to provide their children with necessary medical treatment.

JFC provides the following arguments in support of its position:

1. Federal Law Should Not Support Faith-Healing in Lieu of Medical Treatment, When Such a Policy Results in Unnecessary Harm, Suffering, and/or Death to Children.

Parents rejecting all forms of medical treatment are subjecting their children, in some case, to prolonged agony, permanent disabilities, and/or slow torturous deaths. In one case, the parents of a two-year-old child made frantic calls to religious members to pray for their child who aspirated a bite of banana. The child died after an hour of struggling for oxygen.[2] In February 2001, a 13-year-old living in Denver died after her parents, for religious reasons, refused her medical care for a treatable form of diabetes.[3] Another teenager ran away from home after her parents refused her medical assistance for fainting spells. The police returned her to her father, but she died of a ruptured appendix three days later.[4]

Each of these children and many others could have been saved by appropriate medical attention. The results of a study published in the April 1998 issue of *Pediatrics* determined that of 172 children who died between 1975 and 1995 (and where parents had withheld medical care for religious reasons), 140 of these fatalities were from conditions for which survival rates with medical care exceeded 90%. An additional 18 children would have had expected survival rates of 50%, and only three of the remaining 24 children would not have benefitted significantly from any medical treatment.[5] (The study did not include any medical data from an additional 78 dead children found buried in

1998 behind the Oregon sanctuary of the Followers of Christ Church. This church explicitly forbids conventional medical treatment.)[6]

Federal law does not support sexual or physical abuse of children or the withholding of nutritional necessities.[7] Similarly, CAPTA should not support the withholding of medical care when it directly places children in danger of preventable physical suffering, harm and/or death.[8]

2. U.S. Supreme Court Case Law Does Not Support a Parent's Right to Withhold Medical Treatment From Their Children.

In Prince v. Massachusetts, 321 U.S. 158 (1944), the U.S. Supreme Court upheld a child labor law conviction against a parent who had required her child to distribute religious leaflets on the street. Rejecting the freedom of religion defense, the Court stated, "The right to practice religion freely does not include the liberty to expose the community or a child to communicable disease, or the latter to ill health or death [citation omitted]. ....Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances to make martyrs of their children before they have reached the age of full and legal discretion...."[9] CAPTA's religious exemption runs contrary to the U.S. Supreme Court's construction in Prince of religious freedom under the First Amendment. Moreover, according to the Prince opinion, a parent's right to freedom of religion does not supercede a child's right to good health.

3. Religious Exemptions Do Not Provide Children in Faith-Healing Sects with "Equal Protection" Under the 14th Amendment.

CAPTA's religious exemption reflects an abandonment of the conditions for state participation in CAPTA with respect to one class of children – those affiliated with religious faith-healing sects. CAPTA sanctions the withholding of medical care from the children of faith-healers and effectively releases their religiously motivated caretakers from liability for abuse and neglect. "Such disparate treatment based solely upon religious criteria violates the ... Equal Protection Clause of the Fourteenth Amendment...."[10] All children deserve equal protection of the laws, and no subgroup of children should be exempted by CAPTA from this protection because of the religious beliefs of their parents.

4. CAPTA Provisions Requiring a State to Enact Laws Permitting Child Protective Services to Intervene on Behalf of Ill Children Are Inadequate to Address the Needs of these Children in Danger.

CAPTA §5106i(b) mandates that states enact statutes directing child protection agencies to intervene and pursue medical treatment through a court order for any child known to be at risk of serious harm or death because medical treatment is being withheld by a legal guardian. This federal provision, however, is not sufficient to protect children from harm or death, because in many cases these children do not come to the attention of child protective services in time for the agency to take effective preventative action. In

other words, CPS's family preservation directive interfere's with a more aggressive approach to intervention. Sometimes the only people who know of a child's illness are the other members of the religious group called upon to pray for the child. These persons are unlikely to report the child's condition to state authorities, and CAPTA does not contain a third-party reporting requirement covering children in faith-healing sects. Thus, governmental authorities have no reliable way to ascertain when child protective services should intervene on behalf of a particular child.

[1] E-mail from Rita Swan, Director, Children's HealthCare Is A Legal Duty, Inc., to Kimberly Randall, Legal Researcher, Justice for Children (June 15, 2001, 11:41 EST) (on file with author).
[2] Seth Asser and Rita Swan, *Child Fatalities From Religion-motivated Medical Neglect*, 101 Pediatrics 625 (April 1998).
[3] Denver Post, "*A Healthy Devotion to Kids*," Sect. Denver & The West; p. B-01, Feb. 08, 2001.
[4] Asser and Swan, *supra* note 1.
[5] Id.
[6] Denver Post, *supra* note 2.
[7] The San Diego Union-Tribune, *Faith Healing Faulted in Deaths: Study says children's ailments were curable*, Sect. Local; Ed. B-3, pp. 7-8, April 7, 1998.
[8] *See* American Academy of Pediatrics, Committee on Bioethics. Religious objections to medical care. Pediatrics. 1997; 99:279-281; American Medical Association House of Delegates Resolution H-60.961. Chicago, IL: 1993; National District Attorneys Association. Official Policy Position. Exemptions From Child Abuse Protection. Alexandria, VA: National District Attorneys Association, 1991; and National Committee for Prevention of Child Abuse. Position statement. Chicago, IL: National Committee for Prevention of Child Abuse, November 1990 (each calling for the complete repeal of religious exemptions in child abuse and neglect, and criminal statutes).
[9] Prince v. Massachusetts, 321 U.S. 158, 166-70 (1944).
[10] Brief of Amici Curiae "Children's Healthcare is a Legal Duty, Inc. and American Professional Society on the Abuse of Children" at 6, (quoting City of Boerne v. Flores, 521 U.S. 507 (1997)); *see also*, James Dwyer, *The Children We Abandon: Religious Exemptions to Child Welfare and Education Laws as Denial of Equal Protection to Children of Religious Objectors*, 74 N.C.L. Rev. 1321 (1996).

APPENDIX H – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY THE NATIONAL NETWORK TO END DOMESTIC VIOLENCE.

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Testimony Submitted to the Subcommittee on Select Education of the Committee on Education and the Workforce
U. S. House of Representatives
For the Hearing on CAPTA: Successes and Failures at Preventing Child Abuse Prevention and Neglect
By the National Network to End Domestic Violence

The National Network to End Domestic Violence is a membership and advocacy organization made up of 54 state domestic violence coalitions representing more than 2000 local domestic violence programs. These state domestic violence coalitions work to ensure that emergency and long term services are available for victims of domestic violence on the state and local level. These coalitions have identified housing as a critical missing link in the safety net for victims. NNEDV urges Congress to address this gap by reauthorizing and enhancing the modest transitional housing program created by the Violence Against Women Act 2000. Although this important program was identified as a priority by local, state and national domestic violence and housing organizations, it was only authorized for one year, and did not receive any funding in the 2001 federal budget. We are asking for reauthorization of the transitional housing assistance authorized last year in the VAWA 2000 at $50 million for FY 2002-2006.

Domestic violence is a pervasive problem that affects women of all backgrounds in communities across America. According to the *Bureau of Justice Statistics: Special Report on Intimate Partner Violence* released in May 2000, about 1 million violent crimes were committed against people by their intimate partner in 1998.[1] Of these 1 million incidents, 85% were crimes committed against women. In addition:

[1] Rennison, C. M. and S. Welchans, Intimate Partner Violence, Bureau of Justice Statistics, U.S. Department of Justice, (2000).

- In 1998, nearly 3 out of 4 victims of intimate partner homicides were women[2]

- Between 1993 and 1998 women ages 16-24 experienced the highest per capita rates of intimate violence[3]

- Between 50 - 70 % of men who abuse their female partners also abuse their children[4]

In addition to the devastating effects on individual lives, domestic and sexual violence take a great toll on society and community. From the workplace to the schoolyard, violence against women spills over into public life, and undermines our efforts to create safe and thriving communities. According to the American Medical Association, family violence alone costs the nation an estimated $5 to $10 billion annually in medical expense, police and court costs, shelters and foster care, sick leave, absenteeism and non-productivity.

The federal government has taken a leading role in addressing the epidemic of violence against women. In 1993, Congress passed the landmark Violence Against Women Act, strengthening federal laws against domestic violence, sexual assault and stalking, and providing billions of dollars in new grant programs. Last year Congress reauthorized the Act, authorizing 3.3 billion dollars over five years to address the domestic violence, sexual assault and stalking

A successful response to the violence includes a continuum of services, from an effective law enforcement response to safe and confidential victim services. VAWA programs include law enforcement, prosecution and victim services, grants targeted to rural communities, grants to encourage arrest, judicial training, safe havens for children, rape prevention and education, legal assistance for victims and transitional housing. Taken together, these programs help create a seamless response to violence against women.

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[2] Id.
[3] Id.
[4] Straus, M. and R. Gelles, Physical Violence in American Families, (1996).

Transitional housing, the next logical step, was authorized in VAWA 2000 for only one year with the understanding that the program would be reconsidered as a part of CAPTA this year.

The program that was authorized under VAWA would have made grants available to assist with short-term housing assistance for women fleeing violent homes. Assistance can be in the form of money for utilities, rent security deposits and other expenses incurred when moving to avoid abuse. The program also provides for support services designed to enable a survivor of domestic violence to find safe and stable housing. These services can include counseling, transportation, childcare and employment counseling. Unfortunately, this program was not funded in 2001. It is critical that these vital, lifesaving programs are authorized under CAPTA for FY 2002-2006.

Studies show that one of the biggest problems faced by women leaving abusive relationships is where to go. For example:

- 56% of cities surveyed by the US Conference of Mayors identified domestic violence as a primary cause of homelessness[5]

- A 1990 Ford foundation study found that 50% of homeless women and children were fleeing abusive homes.[6]

- A 1995 survey of homeless adults in Michigan found that physical abuse / being afraid of someone was most frequently cited as the main cause of homelessness.[7]

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[5] US Conference of Mayors. A status Report on Hunger and Homelessness in America's Cities: 2000.
[6] Zorza, Joan, "Woman Battering: A Major Cause of Homelessness," Clearinghouse Review, vol.25, no. 4 (1991).
[7] Douglass, R. The State of Homelessness in Michigan: A Research Study, Lansing, MI: Michigan Interagency Committee on Homelessness (1995).

> Shelter providers in Virginia report that 35% of their clients are homeless because of family violence. This same survey found that more than 2,000 women seeking shelter from domestic violence facilities were turned away.[8]

These are just some of the statistics that indicate a need for women fleeing violent relationships to have a safe, affordable place to stay during the long term process of rebuilding their children's and their lives. Domestic violence shelters are important and effective emergency protection for victims of domestic violence. However, they are temporary in nature, and necessarily so. A typical emergency shelter can house a woman and her children for and average of thirty days. Beds must be available for those victims in the most immediate danger- those seeking shelter from potentially imminent and fatal violence in their homes.

Victims who must leave emergency shelters after the initial crisis still face many challenges in rebuilding their lives and remaining free from violence. These include finding employment, childcare and other services for their children, ongoing medical care, and safe and affordable housing. Women fleeing abusive relationships often find themselves choosing between homelessness and abuse, both of which are dangerous and potential fatal choices.

Since economic control is a tool often used to keep a battered woman from leaving, many batterers keep their intimate partners from educational opportunities, prevent them from working or cause them to lose their jobs, and even keep them from having any money of their own. When these women leave a shelter and have no family or friends to stay with, they are often faced with returning to their abuser or living on the streets. Both options are extremely dangerous. Transitional housing programs address not only the need for safe housing, but also the skills battered women need to rebuild their lives. These programs assist women in obtaining job training, employment, child care, transportation,

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[8] Virginia Coalition for the Homeless, 1995 Shelter Provider Survey, Richmond, VA, Virginia Coalition for the Homeless (out of print).

counseling and other supportive services that are a critical part of recovering from the impact of domestic violence.

One example of such a facility is Middle Way House, Inc. in Bloomington, Indiana. The facility services include childcare, legal advocacy, childcare and parenting workshops, support groups and life skills development activities such as pre employment training and assertiveness training. Each family is assigned a case manager to identify goals and help these families gain residential stability, increased income, and greater self-sufficiency. Transitional housing programs such as these provide a holistic approach to helping battered women gain the support and training they need to establish a violence free life for themselves and their children.

Another Example is Elizabeth Stone House in Jamaica Plain, Massachusetts. The program includes components similar to those in Middle Way House in terms of childcare, counseling and job training. In addition, this program includes counseling for depression and substance abuse, problems that may exist concurrently with domestic violence. Support services also help women train for and acquire jobs that pay a living wage or start their own business.

A third example in Chicago most closely models the direct assistance program that was authorized under VAWA. The South Suburban Family Shelter helps women who need assistance with rent and utilities payments in order to leave an abusive relationship. The program provides counseling for mothers and children, as well as offering financial advice. They also work with the victim's employer to help protect her from harassment or abuse at work. Of the women that participate in the program, Executive Director Diane Bedrosian says, "Most often they don't need help for the rest of their lives, they just need help for a few months, just to get them going. It's just a little bridge to get over the gap."

Years of physical and emotional abuse take their toll on women and children in many different ways. While leaving an abusive home takes them out of immediate physical

danger, the emotional wounds inflicted by an abusive partner often take longer to heal. Transitional housing programs offer women the both the time and resources they need to rebuild their self esteem and receive much needed educational and career training while also providing support and care for their children. These programs can truly make the difference between temporarily escaping a violent home and permanently breaking the cycle of violence.

The Violence Against Women Act and other federal legislation has greatly increased the options of battered women and their children escaping from violent homes. By providing funding for core services such as shelters and hotlines as well as funds to train police, prosecutors and judges, VAWA has helped significantly in the struggle to eradicate violence against women. Funding for transitional housing is the logical and necessary next step to ensure that these efforts are effective in breaking the cycle of violence. It is critical that this program be reauthorized under CAPTA for FY 2002-2006.

APPENDIX I – SUBMITTED FOR THE RECORD, LETTER AND STATEMENT BY THE McAULEY INSTITUTE.

McAULEY INSTITUTE

August 14, 2001

Honorable Peter Hoekstra
Chairman
Subcommittee on Select Education
House Education and the Workforce Committee
2181 Rayburn House Office Building
Washington, DC 20515

RE: Statement for the record for August 2, 2001 hearing, "CAPTA: Successes and Failures at Preventing Child Abuse and Neglect"

Dear Chairman Hoekstra:

The McAuley Institute, a 501(c)(3) organization, was founded in 1983 by the Sisters of Mercy of the Americas to address the problem of inadequate housing for low-income families in the United States. Our mission is to support the work of community-based partners to create decent, affordable, accessible housing. A certified Community Development Financial Institution (CDFI) and technical assistance provider to Community Housing Development Organizations (CHDOs), McAuley is the *only* national housing intermediary explicitly focused on serving the needs of poor women and children.

Since 1983, McAuley has assisted over 2,100 community groups in 49 states and the District of Columbia. McAuley's below-market rate loans have helped finance over 5,700 units of housing. More than three-fourths of the organizations we work with are led by women. Over one-third are faith-based. McAuley's loan funds serve housing for families earning less than 80 percent of area median income. Residents include very low-income families, the majority headed by women, and individuals who are homeless, disabled, elderly, immigrants, domestic violence survivors, former inmates and women with HIV/AIDS.

Because many of the groups to whom we provide technical assistance and financial support are assisting women fleeing domestic violence, **we write to urge the Committee to include in its reauthorization of CAPTA, the Transitional Housing Assistance Program for survivors of domestic violence authorized in the Violence Against Women Act last year** (sec. 319 of P. L.106-386, Oct. 28, 2000). The extension of this modest housing assistance program can yield significant results in addressing a form of family and intimate partner violence inevitably connected to child abuse and neglect.

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The McAuley Institute recently submitted comments to the congressionally chartered Millennial Housing Commission, charged with making recommendations about housing policy. Enclosed is an excerpt from those comments addressing the need for transitional housing.

Sincerely yours,

Josephine Ann Kane
Executive Director

Enclosure

Housing Needs of Domestic Violence Survivors

Transitional housing for persons facing homelessness as a result of domestic violence -- primarily women -- is a growing social need. In some places, the growth is exacerbated by the growth of immigrant populations with cultures tolerant of domestic abuse. Too often, because of programmatic and funding constraints, the permissible length of stay in emergency shelters for battered women does not provide enough time to begin the task of restoring order to their and their families' lives.

Transitional housing is the rung above emergency shelter on the battered woman's ladder toward a permanent, safe, secure and stable home. Many domestic violence service providers and community-based housing groups across the country are working to provide housing and critical supportive services to survivors by piecing together programs from a patchwork of public and private, local, state and federal sources. Federal acknowledgement of the particular housing needs of survivors is critical to mount the support that can help battered women and their children. Without stable, affordable housing, these families are denied their rightful place as self-sustaining and productive members of society.

Connection to Homelessness

Survivors, at the least those who seek refuge in homeless or battered women's shelters, lack the resources to pursue other temporary or permanent housing options. Existing federal programs, already straining under the weight of serving other homeless individuals, are serving the needs of survivors inadequately, at best.

Domestic violence is a significant factor in homelessness. In a ten-city 1998 study, 22 percent of 77 homeless parents (mostly mothers) reported leaving their last place of residence due to domestic violence. In a 1999 survey by the U.S. Conference of Mayors, 57 percent of cities responding identified domestic violence as a *primary* cause of homelessness. Meanwhile, the ranks of homeless families are growing. The Mayors found requests for emergency shelter by homeless families with children had increased by 68 percent. Although all of these families may not be victims of domestic violence, the presence of survivors among the homeless is certainly growing.

HUD reports that 13 percent or more of homeless clients in families report leaving their last residence because of domestic violence in the household. And 45 percent of parents in homeless families report experiencing or witnessing family violence. In 2000, 62 percent of HUD homeless programs reported serving at least some persons who reported experiencing domestic violence situations. Of 2,643 homeless projects funded in 2000, 1,644 provided assistance to survivors of domestic violence among others.

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Clearly, homeless programs currently provide life-saving services to domestic violence survivors. However, the typical homeless shelter is plainly inadequate to meet the particular safety and security needs of women and families requiring protection from an abuser. Programmatically and environmentally, homeless shelters are not suitable places for children and frequently lead to family break-up. This is especially traumatic for children fleeing domestic violence with their mothers because of their need to feel connected and safe.

HUD McKinney-funded Homeless Programs

Domestic violence survivors may be eligible for the HUD homeless programs funded under the McKinney-Vento Homeless Assistance Grant Programs, the Shelter Plus Care, Supportive Housing, Section 8 Mod Rehab Single Room Occupancy and Emergency Shelter Grant Programs, but, as indicated, these may not be suitable for battered women, particularly those with children. Moreover, resources of these programs fall short of the needs of communities nationwide to address problems of chronic and short-term homelessness, whatever the demographics of the homeless population locally. The HUD FY 2002 budget proposes to fund homeless programs at $1.023 billion, the same level as 2001. The scarcity of resources is exacerbated by the federal requirement that funding for permanent housing renewals in some of these homeless programs come from the core homeless assistance grant which should be directed to serving those whose needs are not currently served.

HHS-funded Shelters for Battered Women

The need for shelters and services for battered women authorized under the Family Violence Prevention and Services Act far outstrips demand. In a mini-survey of 32 shelters in FY 2000 conducted by the National Coalition Against Domestic Violence, at least 4,743 women were turned away due to lack of space. This same survey discovered that in the same year more than 11,740 women and children who were not safe in their homes, received emergency shelter from these programs. Although transitional housing can be supported with emergency shelter funding, the money also supports a range of services including, but not limited to, legal advocacy, counseling, children's programs, rape and sexual assault crisis intervention, substance abuse treatment, job training, transportation, child care and 24-hour hotlines.
The Administration's FY 2002 budget would fund FVPSA at $117 million, $58 million less than the authorized level.

Shortcomings of Existing Systems

Homeless shelters by their nature are ill-equipped to meet even the short-term needs of survivors and their families. In addition, victims may face eviction from the public housing, Section 8 tenant and project-based programs as well as private market housing if their batterer causes disruption that threatens the safety, security and

peaceful enjoyment of other tenants or poses a health and safety risk to others. Similarly, because battered women's shelters frequently limit the duration of stay and often have no, or inadequate, provision for children, families may be forced to be separated at a turbulent time when stability and cohesiveness are critically important. The dilemma is compounded for a poor victim because, once she has exhausted her stay in the shelter system, she may – as a result of TANF – be forced to remain with her abuser due to an inability to afford rent. And many middle and upper income women find access to a checkbook and other family resources cut off when they flee their abusers.

The critical importance of the homeless and battered women's shelters notwithstanding, the shortcomings of these systems to respond to the needs of persons fleeing abusive situations argue in favor of responses that offer a way-station for women and their families as they move beyond the immediate safety and security of a shelter and toward permanent housing. Short-term housing assistance and targeted supportive services are needed to help survivors bridge the gap between financial and emotional dependency on their abusers and productive, healthy, life-sustaining homes for themselves and their families.

McAuley Institute urges the Commission to consider recommending that Congress take action on federal policy response described below.

VAWA 2000 Transitional Housing Assistance

In October 2000, a $25 million authorization was enacted for short-term housing assistance for persons fleeing domestic violence or sexual assault for whom homelessness is imminent due to the unavailability or inadequacy of emergency shelter. The program was authorized for 12 months as part of the Violence Against Women Act, but an appropriation was not made. An extended reauthorization and funding for FY2002 is urgently needed.

Grants administered by the Family Violence Prevention Services Office in HHS' Administration for Children and Families would be provided presumably to battered women's shelters and housing nonprofits. Funds could be used for rent or utilities payment, assistance with related expenses such as security deposits and the costs of relocation to transitional housing, as well as support services to aid in the identification and securing of permanent housing and such supports as transportation, counseling child care, case management and employment counseling.

The assistance would be available for 12 months with a waiver to permit an additional six months of help. Grantees would be required to report annually to the Congress on the number of persons eligible to be assisted who could not be due to the unavailability of housing. Domestic violence service providers and, hopefully,

nonprofit housing organizations, would be eligible to administer the grants from FVPSA

APPENDIX J – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY THE NATIONAL RESPITE COALITION.

Testimony Submitted by the
National Respite Coalition
to
The Subcommittee on Select Education
The Committee on Education and the Workforce
U.S. House of Representatives

For the Hearing on
CAPTA: Success and Failures at Preventing Child Abuse and Neglect

August 2, 2001

The National Respite Coalition welcomes the opportunity to submit testimony to the Education and Workforce Select Education Subcommittee for the hearing on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). We are particularly supportive of the reconsideration of Title II, the Community Based Family Resource and Support Program, which is the only federal program currently dedicated solely to child abuse and neglect prevention. With this testimony, we are also responding to Congressman Roemer's request for information which documents the effectiveness of community-based programs, in particular respite and crisis care, in preventing child abuse and neglect.

The National Respite Coalition is the policy division of the ARCH National Respite Network, a membership organization composed of respite and crisis care providers, state and local agencies which support respite care, parents and caregivers who use respite services, and 30 statewide respite coalitions. The ARCH Network also houses the ARCH National Resource Center on Respite and Crisis Care.

What is Respite?

Respite, or temporary relief for the primary caregivers of children with special needs and other children at risk of abuse or neglect, has been shown to be a successful, cost-effective component of comprehensive family support. It is also the service most often requested by families. Many models of in-home and out-of-home respite exist, depending on family need and community availability.

Respite may be available on a planned basis for families under constant caregiver stress who simply require time to shop, tend to either their own needs, or those of another family member.

Respite also is available on an emergency basis in the form of crisis care or crisis nursery services and is utilized by families or caregivers seeking safe havens for their children in the midst of a crisis brough on by substance abuse or mental health problems, or during a housing, health, domestic violence or employment crisis.

The Demand for Respite and Crisis Care Exceeds the Supply

Despite families frequent requests for respite or crisis nursery care, services are in short supply, and the demand is growing because of unrelenting reports of child abuse and neglect,

changing family structures that bring added stress, and the neglected needs of children in domestic violence situations. In addition, children with disabilities, without adequate family support, are at increased risk of abuse or neglect.

- During an average week, nearly 1,500 families representing 3,425 children are turned away from respite and crisis care programs because resources to meet the need are absent. In a 1998 survey of respite programs nationwide, half had families waiting for respite care at the time of the survey (ARCH National Resource Center on Respite and Crisis Care, 1999).

- In 1999, nearly 3 million reports of child maltreatment were made to child protective service agencies. Of the 60.4% of these reports that were investigated, states found that 826,000 children were the victims of substantiated or indicated child abuse and neglect (U.S. Dept. of Health and Human Services, Press Release, April 2, 2001).

- Without adequate family support, it is estimated that children with disabilities are 3.76 times more likely to be victims of neglect, 3.79 times more likely to be physically abused, 3.88 times more likely to experience emotional abuse, and 3.14 times more likely to be sexually assaulted than children without disabilities (Sullivan & Knutson, 2000).

- It is estimated that 2 to 4 million women are victims of domestic violence, and between 3.3 and 10 million children are exposed to domestic violence, each year (Novello, Antonio, 1992; Future of Children, Winter, 1999). Although most children exposed to domestic violence do not go to shelters, only 56% of 1,886 community-based domestic violence providers offered some form of services for nonresident children (Saarhoff and Stoffel, 1999).

- Grandparents, often without adequate family supports, are increasingly acting as primary caregivers of their grandchildren. Currently, more than 2.5 million grandparent-headed households are raising 3.9 million children in the U.S. The number of families without either parent present increased 53% between 1990 and 1998 (U.S. Bureau of the Census, 1998 Current Population Survey). Despite these statistics, most states or counties do not fund respite for these caregivers (Generations United, 2000).

Respite and Crisis Care are Effective Deterrents to Child Abuse and Neglect

Research has demonstrated that respite is a successful, effective and cost-saving child abuse and neglect prevention strategy. One of the first comprehensive, comparative respite care studies of families with a disabled member found significant beneficial outcomes. This is especially noteworthy, given that children with disabilities are at much greater risk of abuse or neglect. But many families facing serious economic, health or substance abuse emergencies are also at high risk. Subsequent studies have found significantly reduced incidence of child abuse and neglect, reduced out-of-home placements, and as importantly, an increased optimism about the family's future capacity to provide on-going care at home.

- **Respite has been shown to improve family functioning, improve life satisfaction, enhance the capacity to cope with stress, and improve attitudes toward the family member with a disability (Cohen and Warren, 1985).**

- **Very high percentages of children in high-risk families using crisis respite have avoided reports to child protective services, and most remain living safely with their families. One Iowa crisis program found a 13% decrease in the reported incidence of child abuse and neglect in the initial four pilot counties after the program's implementation (Cowen, Perle Slavik, 1992).**

- **An evaluation of a respite care project targeted to families in a high risk community found that: one out of four mothers reported positive changes in their relationships with their children, and 50 percent of the mothers noted positive changes in their children's behavior. Of the 25 families referred to the project following a request for child placement, over two-thirds did not proceed with placement plans. (Home, A. and Darveau Fournie, L. , 1995).**

- **In a recent evaluation study of families of children at risk of abuse or neglect who utilized Family Support Services of the Bay Area's Respite Care Program in northern California, over 90% of the families using the service reported reduced stress (93%), improved family relationships (90%), improved positive attitudes toward child (93%), and other significant benefits that can help reduce the risk of abuse (Owens, Sandra, et al, School of Social Welfare, Berkeley, California, 1999).**

- **In April, 1999, the Minnesota Dept. of Human Services, Family and Children's Services Division, reported that crisis nursery clients in 15 crisis nursery programs serving 18 counties showed a 67% reduction in child protection involvement after using nursery services. The Hennepin County Children and Family Services Department's evaluation of the Greater Minneapolis Crisis Nursery found that families with no prior child protection involvement had a 0% risk factor of subsequent child protection involvement six months after their use of the Nursery's services. Families with prior child protection involvement who used the Nursery had only an 8% risk factor compared with an 84% risk factor for families who did not use the Nursery.**

- **The Relief Nursery in Eugene, Oregon, reports that in 1997-98, 91.3%of children attending the Nursery were free of any reports of abuse, and 89% had no involvement with foster care. This is remarkable, because two-thirds of the families had more than ten risk factors, and 95% had five or more. A family with five risk factors is deemed to be at extremely high risk for abuse and neglect.**

- **Of the more than 25,000 children whose families used the services of the Vanessa Behan Crisis Nursery (a 24-hour, 7-day-a week shelter program for at-risk children in Spokane, WA), not one has sustained a life-threatening injury since the nursery opened its doors in 1987 (U.S. Dept. of Justice, Safe from the Start," November,**

2000).

- **Preliminary data from an ongoing research project of the Oklahoma State University on the effects of respite care, found that the number of hospitalizations, as well as the number of medical care claims decreased as the number of respite care days increased (FY 1998 Oklahoma Maternal and Child Health Block Grant Annual Report, July 1999).**

- **An evaluation of the Iowa Respite Child Care Project for families parenting a child with developmental disabilities found that when respite care is used by the families, there is a statistically significant decrease in foster care placement (Cowen, Perle Slavik, 1996)**

- **A study of Vermont's 10 year old respite care program for families with children or adolescents with serious emotional disturbance found that participating families experience fewer out-of-home placements than nonusers and were more optimistic about their future capabilities to take care of their children (Bruns, Eric, November, 15, 1999).**

- **In Nebraska, a newly formed statewide lifespan respite program conducted a statewide survey of a broad array of caregivers who had been receiving respite services, and found that one out of four families with children under 21 reported that they were less likely to place their child in out-of-home care once respite services were available. In addition, 79% of the respondents reported decreased stress and 58% reported decreased isolation, both of which are often precursors to abuse (Jackson, Barbara, Munroe-Meyer Institute, University of NE Medical Center, January 2001).**

New National Pilot Study on Respite and Crisis Care Outcomes Confirms the Potential for Program Effectiveness

Despite the overwhelming evidence to date, more and better data collection is required to demonstrate respite's positive effect on child abuse and neglect prevention. In response, the ARCH National Respite Network and Resource Center developed a guide for evaluating and reporting outcomes of respite and crisis care. This work was undertaken during 1998 and 1999, and resulted in a guidebook, *Evaluating and Reporting Outcomes: a Guide for Respite and Crisis Care Program Managers,* published in December 1999.

Early in 2000, The ARCH National Respite Network and Resource Center issued an RFP (Request for Proposals) inviting planned and crisis respite programs to voluntarily pilot the questionnaires in the guidebook and evaluate their utility. Programs proposing to be pilot sites could also request on-site training and technical assistance on outcome evaluation.

Twenty-nine programs in across the United States volunteered to participate. The selected sites represented programs in the Midwest, South, East Coast, West Coast, and Southwest, as well as Alaska and Hawaii. A mix of crisis and respite programs serving children and their families were selected as well as programs that served people across the lifespan. Sites were located in large urban areas, as well as in smaller, more rural communities. ARCH provided fourteen of the programs with in-person training and technical assistance in developing and conducting an outcome evaluation. Seventeen programs remained engaged in the project and participated in the field-testing of the instruments.

Outcome Indicators of Respite and Crisis Care

Preliminary data from these pilot sites suggest that respite and crisis care are promising approaches to reducing family stress, improving family relationships and reducing the risk of child maltreatment. While the outcomes measured by the ARCH evaluation instrument are positive and very likely to be indicative of actual trends, they are only preliminary trends. ARCH intends to continue to expand the pool of programs collecting outcome data. This will provide not only beneficial information to individual programs, but aggregate national data on the effectiveness of respite care services in reducing/preventing child abuse and neglect.

The following information on outcome indicators of respite and crisis care was derived from a paper "Developing a Model for Measuring Outcomes of Respite Care: Leaping Into the Sea of Inquiry," authored by Raymond S. Kirk, Ph.D., School of Social Work, University of North Carolina at Chapel Hill, NC and Casandra Wade, MS, Coordinator, ARCH National Respite Network and Resource Center, for an international conference on respite care in Sydney, Australia, September, 2001.

Based on their knowledge of the families activities and past history, project managers reported that in some instances caregivers were likely under reporting on issues such as maltreatment, out of home placement and marital status. Furthermore, because this was a field test of the instruments and the evaluation model, data collection methods varied across sites and the numbers of clients interviewed was small. Even with some qualifications, the preliminary data are very encouraging.

Maltreatment/Out-of-Home Placement. The caregiver reports indicate that the risk for out-of-home placements and abuse and neglect is reduced with the provision of respite care. Although parents were reluctant to admit that their child would have been at risk for maltreatment had crisis care not been available, the same group reported that the crisis care they received helped protect their child from danger. Fifteen (15%) percent of the caregivers reported that it was "somewhat likely" to "highly likely" that their child might have been mistreated or neglected if crisis care had not been available, and an additional 15% responded "not sure," yet 81% reported that the crisis care they received helped protect their child from danger.

Caregiver Stress The responses on caregiver stress are promising and indicate that with planned or emergency respite, caregivers experience reduced stress related to the care of their dependant family member. Ninety percent (90%) of the caregivers found that crisis care reduced their stress "quite a bit", "very much" or "extremely," with "extremely" accounting for nearly 3/5 (57%) of

respondents. In addition to reducing stress, crisis care enabled caregivers to work on issues that contributed to their crises, such as housing, employment, alcohol and drug problems or other problems. Not only were respondents able to "work on" these problems, as a group they were able to resolve or make substantial progress on these problems. With respect to problem resolution, 81% reported "quite a bit," "very much" or "extremely," with "extremely" accounting for 40% of respondents.

Family Relationships More than half (54%) reported that with respite, their relationship with their dependant family member had improved "quite a bit," very much," or "extremely."

Further field testing and minor modifications to data collection methods are necessary. However, data collected using the instruments in their present form indicate that the outcomes expected from crisis and respite care programs (such as reduced stress, reduced likelihood of out-of-home placements, and reduced risk of abuse and neglect) are very likely being achieved. If these trends continue throughout the second phase of the project, they will clearly demonstrate the value of both planned and crisis respite care and will continue to make a strong case for increased support of these programs.

Legislative History: CBFRS Since 1997

In 1997, the "Temporary Child Care for Children with with Disabilities and Crisis Nurseries Act," (TCCA) was consolidated into Title II, the Community-Based Family Resource and Support Act. TCCA was a highly successful federal demonstration program, spawning the development of hundreds of respite and crisis care programs in nearly every state. Years after the conclusion of the TCCA federal grant program, it is estimated that nearly 80% of these respite and crisis care programs are still functioning with other sources of federal, state and private funding. To date, even though CBFRS is providing considerably fewer resources specifically for respite and crisis care than TCCA was able to provide because it was a dedicated program, CBFRS remains the only federal program available to provide start-up dollars for critically necessary new respite and crisis care programs.

According to the federally funded FRIENDS Resource Center which provides expert training and technical assistance to the State CBFRS lead agencies, the CBFRS program has accomplished much in the last 5 years with limited resources. For example, 37 states report that respite care and crisis nurseries have been funded and even more states are funding critical services such as home visiting (although it is unclear from state's annual reports if CBFRS is the sole source of funding for these programs in all these states). A range of other family support, family resource and child abuse and neglect prevention programs, as well as broad-based networks for enhanced service delivery have been funded as well. FRIENDS has produced an outcome evaluation guide, similar to the ARCH guide for respite and crisis care programs discussed above, and is in the process of designing a similar field test for CBFRS programs to conduct outcome evaluation for programs funded under the Act.

However, despite the excellent work of the FRIENDS Resource Center to assist states in designing, implementing and evaluating CBFRS programs, there is wide diversity in how states interpret the Act and to what extent they are meeting the original intent of the law. NRC strongly supports the continuation and strengthening of Title II to clarify the purposes of the Act, simplify the

language so that it is more understandable and workable, and refocus attention on funding core community-based child abuse and neglect prevention programs.

Conclusion and Recommendations

The National Respite Coalition is in full support of the recommendations and proposed draft language put forward on Title II by the National Child Abuse Coalition:

- **Make Prevention a National Priority**. Preventing abuse and neglect of children from happening in the first place should be a national priority. Billions of dollars are spent on protecting and serving children once they are in the CPS and foster care system, while only minimal investments are made in up-front prevention. Redirecting CAPTA will keep children safe and avert the long-term consequences and more costly out-of-home placements that result from serious abuse.

- **Strengthen and Clarify Title II's Role to Support Respite and Core Prevention Programs**. CAPTA Title II should be clarified and simplified so that it is the basic source of funding for proven effective community-based prevention programs, including strengthening language to assure start-up and ongoing funding for the identified core programs of respite care, home visiting, parent mutual support, parent education, and family resource services.

- **Increase Funding: Critical for Prevention**. Funding for both Titles I and Title II should be authorized at $500 million each, which represents a modest commitment to support prevention of child abuse and neglect. It is also the amount necessary to begin to bring promising practices to scale and to keep local programs from having to turn families away from effective prevention services they are seeking voluntarily.

- **Strengthen Involvement with Families of Children with Disabilities, Parents with Disabilities**. Recognizing that children with disabilities are at increased risk of abuse and neglect and that abuse is a significant cause of disabilities, NRC strongly supports all existing and NCAC proposed language in CAPTA Title II, which requires the involvement of families of children with disabilities, parents with disabilities, and agencies and organizations who work with families of children with disabilities to be an integral component of every aspect of program planning, implementation and evaluation.

- **Enhance Accountability**. NRC also supports the National Child Abuse Coalition's proposal to increase program and state accountability through improved reporting requirements to demonstrate effective and efficient use of funds under and in accordance with the Act.

Finally, the NRC urges that respite and crisis care, which had its original authorization ("The Temporary Child Care Act for Children with Disabilities and Crisis Nurseries Act) consolidated into Title II in 1997, should remain as core services under Title II. This not only ensures that effective community-based prevention programs that families want and need, such as respite and crisis care,

are being funded, but that the Congressional intent to maintain the integrity of consolidated programs is upheld.

Thank you for the opportunity to submit this testimony. NRC, as a member of the National Child Abuse Coalition, stands ready to assist you in your consideration of the CAPTA reauthorization.

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APPENDIX K – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY CHILDREN'S HEALTHCARE IS A LEGAL DUTY, INC., AND ARTICLE "CHILD FATALITIES FROM RELIGION-MOTIVATED MEDICAL NEGLECT".

Children's Healthcare Is a Legal Duty, Inc.

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Testimony of
Children's Healthcare Is a Legal Duty
Submitted to the
Subcommittee on Select Education
Committee on Education and the Workforce
U.S. House of Representatives
for the hearing on
Child Abuse Prevention and Treatment Act (CAPTA) 2001
Reauthorization
August 2, 2001

Submitted
August 6, 2001

Children's Healthcare Is a Legal Duty (CHILD) is a private organization of more than 450 members in 44 states working to stop child abuse and neglect that is based on religion or cultural tradition. We are best known for our work against religion-based medical neglect of children. Our members include pediatricians, lawyers, other professional advocates for children, and people who have been injured by religion-based abuse or neglect.

CHILD urges the House Committee on Education and the Workforce to remove the religious exemption at Sec. 113. Rule of Construction in the Child Abuse Prevention and Treatment Act (CAPTA), stating as follows:

> (a) IN GENERAL.—Nothing in this Act shall be construed—
> (1) as establishing a Federal requirement that a parent or guardian provide a child any medical service or treatment against the religious beliefs of the parent or legal guardian; and
> (2) to require that a State find, or to prohibit a State from finding, abuse or neglect in cases in which a parent or legal guardian relies solely or partially upon spiritual means rather than medical treatment, in accordance with the religious beliefs of the parent or legal guardian.

Since 1983, CAPTA has required states in the grant program to include failure to provide medical care in their definitions of child neglect.

CAPTA explicitly requires states in the grant program to require medically-indicated care of infants with disabilities. But in 1996 the Rule of Construction was added to CAPTA, allowing those states to give parents in faith-healing sects the right to withhold all medical treatment from children.

In the Rule of Construction, the federal government is depriving children in faith-healing sects of a protection that it offers to all other children. The federal government is discriminating against a class of children.

This federal law saying that parents can withhold all medical treatment from children on religious grounds has emboldened spiritual healing lobbyists to press for more religious exemptions in state law. Only one month after CAPTA was reauthorized in 1996 with the above religious exemption, HB1104 was introduced in Maryland stating that no Maryland law could be construed

1. To establish a requirement that a parent or legal guardian provide a child with any medical service or treatment against the religious belief of the parent or legal guardian;
2. To require or authorize a finding of abuse of abuse, neglect, or violation of a criminal law by a parent, guardian, or other person who has care, custody, or responsibility for supervision of a child for relying, in accordance with the religious belief of the parent or guardian, solely on spiritual means rather than medical treatment for the health care treatment of the child.

The federal law was used as a rationale for creating a *carte blanche* exemption throughout both the civil and criminal codes. It was defeated after extensive work by child advocates, but every year since then, there has been more work to do against religious exemptions in the Maryland legislature. In 2000 Maryland child advocates lost a four-year battle to stop bills giving a religious exemption from blood lead-level testing.

In 1997 Oregon enacted an affirmative defense to manslaughter requiring only that the defendant show that the dead "child or dependent person was under care or treatment solely by spiritual means pursuant to the religious beliefs or practices of the child or person or the parent or guardian of the child or person." Within eight months later, three Oregon City children had died because of their parents' religious beliefs against medical care. All three deaths would have been easily preventable with standard medical care.

After a year of work, child advocates got a bill through the Oregon legislature repealing five religious exemptions, and no children have died of untreated illnesses in Oregon City since the bill became law.

In February of this year spiritual healers persuaded a Georgia House committee to add a religious exemption to the crime of child endangerment in HB453 and lobbied for a religious exemption to child fatality review in SB60.

More than fifty years ago the U. S. Supreme Court ruled that "the right to practice religion freely does not include liberty to expose the community or child to communicable disease, or the latter to ill health or death" and that while "parents may be free to become martyrs themselves," they are not free "to make martyrs of their children." *Prince v. Massachusetts*, 321 U.S. 158 (1944). Yet now we have a federal law allowing parents to withhold lifesaving medical care from children.

We recognize that CAPTA requires states in the grant program to give courts authority to order medical treatment for children over the religious objections of parents. But many sick children in faith-healing sects have not come to the court's attention before they died or suffered permanent harm. Children need both avenues of protection—the possibility of state intervention and a parental duty to care for the child.

Furthermore, we note that HHS has done nothing to implement the judicial authority standard since CAPTA was reauthorized in 1996. In 1990, for example, the Delaware Supreme Court quashed a lower court order for medical care of a Christian Science child stricken with cancer, in part because of a state religious exemption law. *Newmark v. Williams*, 588 A.2d 1108 (1991) The toddler was sent home to die without even sedatives.

For another example, Florida has laws allowing courts to order either medical treatment or prayers by Christian Science practitioners for any child in the state. See Fl. Stat. 39.01(30)(f) and 984.03(37).

Before CAPTA was reauthorized in 1996, HHS had advised Delaware and Florida that their laws violated CAPTA. Since 1996, HHS has taken no action to give Delaware or Florida children equal rights to medical care.

Also before the 1996 reauthorization, HHS had advised states that laws designating faith healing as health care or medical care violated CAPTA because they could impede the courts' authority to order needed medical care for the child. Since 1996, HHS has taken no action to clarify the courts' authority.

In 1995 child advocates emphasized to congressional staffers the importance of a reporting requirement applicable to children in faith-healing sects. Congress did not put a reporting requirement for these children in CAPTA, but did state in the authorizing committee's report that their religious exemption should not "be interpreted to discourage the reporting of such incidences to child protective services nor to exempt any child's situation from State reporting requirements."

In April, 1998, nine national children's organizations and six statewide ones sent a report to HHS urging the Department to implement the reporting requirement. They cited laws of several states in the grant program that offered a religious exemption from reporting when the child's parents have religious objections to medical care and urged HHS to take action against those states. HHS, however, has taken no action and has not issued proposed regulations to implement the CAPTA amendments passed in 1996.

Congress should think long and hard about what it has done in the religious exemption to CAPTA. Does Congress really intend to allow laws that describe religious rituals as appropriate health care for sick children, that indicate to mandated reporters that cases of religion-based medical neglect do not need to be reported to state child protection services, and that limit the courts' authority to order medical care for sick children? What protections does Congress want children in faith-healing sects to have and is Congress willing to give HHS the statutory authority to implement them?

In testimony already submitted to the Subcommittee, the National Child Abuse Coalition calls for removal of the religious exemption from CAPTA this year. The United Methodist Church also calls upon Congress to strike the exemption (see enclosed). With 9 million members, the United Methodist Church is the second largest Protestant denomination in this country.

As the enclosed article in *Pediatrics* indicates, hundreds of children have died because of their parents' religious objections to medical care.

We believe federal law should extend the protections of CAPTA equally to all children regardless of their parents' religious beliefs. CAPTA requires states in the grant program to include failure to provide medical care in their definitions of child neglect and should not deprive one class of children of the protection afforded by this requirement.

Prepared by Rita Swan, President Rita Swan

Child Fatalities From Religion-motivated Medical Neglect

Seth M. Asser, MD*, and Rita Swan, PhD‡

ABSTRACT. *Objective.* **To evaluate deaths of children from families in which faith healing was practiced in lieu of medical care and to determine if such deaths were preventable.**

Design. **Cases of child fatality in faith-healing sects were reviewed. Probability of survival for each was then estimated based on expected survival rates for children with similar disorders who receive medical care.**

Participants. **One hundred seventy-two children who died between 1975 and 1995 and were identified by referral or record search. Criteria for inclusion were evidence that parents withheld medical care because of reliance on religious rituals and documentation sufficient to determine the cause of death.**

Results. **One hundred forty fatalities were from conditions for which survival rates with medical care would have exceeded 90%. Eighteen more had expected survival rates of >50%. All but 3 of the remainder would likely have had some benefit from clinical help.**

Conclusions. **When faith healing is used to the exclusion of medical treatment, the number of preventable child fatalities and the associated suffering are substantial and warrant public concern. Existing laws may be inadequate to protect children from this form of medical neglect.** *Pediatrics* **1998;101:625–629;** ***child abuse, child neglect, child fatality, Christian Science, faith healing, medical neglect, prayer, religion and medicine.***

Despite the great advances of scientifically based medicine, some individuals and groups continue to look primarily outside of modern medicine for remedial care.[1] Applied to minor or self-limited problems, many nonmedical practices are probably benign, but may lead to avoidable morbidity and mortality with more serious ailments.

Claims that prayer or religious beliefs have psychological or other benefits that contribute to illness recuperation are scientifically testable and perhaps supported by some evidence.[2,3] Although some churches have published testimonials claiming that organic and functional diseases are healed by soliciting divine power, this has not been confirmed by scientifically valid measures.[4] Death rates in graduates of a Christian Science college, a group whose central tenets deny the reality of disease and promote avoidance of medical services,[5] have been reported to be higher than graduates of a secular institution.[6]

Although legal precedents have established the right of an adult to refuse life sustaining treatment, they do not allow parents or guardians to deny children necessary medical care. The US Supreme Court stated this principle eloquently: "The right to practice religion freely does not include the liberty to expose the community or child to communicable disease, or the latter to ill health or death . . . Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion. . . ."[7]

Despite this ruling, in late 1974 the US Department of Health, Education, and Welfare required states receiving federal child abuse prevention and treatment grants to have religious exemptions to child abuse and neglect charges.[8] With federal money at stake, states rapidly enacted exemptions for parents who relied on prayer rather than medical care when their children were sick or injured. A decade later nearly every state had these exemptions in the juvenile code, criminal code, or both.[9,10]

A few cases of children who died because of religion-motivated medical neglect have received national press coverage, but most get little or none. Reports in the medical literature are also rare. The American Academy of Pediatrics' first policy statement against religion-based medical neglect in 1988 cited press accounts rather than case reports.[11] Outbreaks of vaccine-preventable disease among groups with religious objections to immunization are reported frequently.[12–14] However, medical citations of fatalities are rare.[14,15] One study of perinatal events reported an Indiana sect that had a threefold increase in infant mortality and an 80-fold increase in maternal mortality compared with the general population.[16] The study reported here describes deaths that have occurred after the federal government required religious exemptions to child abuse and neglect laws.

METHODS

We compiled a list of child fatalities in the United States that occurred during the period from 1975 through 1995. Initial cases were from the files of Children's Healthcare Is a Legal Duty (CHILD), Inc, a nonprofit organization that gathers information on religion-based child abuse and neglect. These cases were collected from newspaper articles, trial records, personal communications, and public documents. With institutional review board approval, police records, coroners' files, and other confidential materials were examined for additional information. During this supplemental search, 4 additional candidates were identified.

Cases were included if the available information, including clinically descriptive histories and/or post mortem medical data, was sufficient to determine the cause of death with reasonable

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medical certainty, the standard for presentation of a medical opinion in most courts. This was assessed by one author (S.M.A.), a pediatrician who has qualified in court to examine records and present expert opinion in child fatality cases.

Cases were excluded if documentation of the cause of death was inadequate or if the history did not indicate that failure to seek medical care was primarily based on a reliance on faith healing. Examples of the latter include children of some Amish communities where the barriers to care are more cultural than theological and children of Jehovah's Witnesses who were denied only blood products and were not expected to be healed by divine intervention.

After considering the underlying conditions and diagnoses that directly contributed to death, children were assigned a likely outcome with commonly available remedial or preventive medically supervised care (Table 1). Because medical advances altered expected mortality rates during the study period, comparisons were based on clinical experience and published statistics of the appropriate era. For chronic conditions (eg, tumors, diabetes) survival was compared with long-term survival rates published in journals or textbooks from the relevant field. For acute problems, such as infections and perinatal complications, the logical comparison was expected mortality during the acute process.

In most cases, the diagnosis permitted an assignment to an expected outcome based on a published statistic. For example, the mortality rate for treated cases of Rocky Mountain Spotted Fever in 1983 was 2%, less than one-third the rate for untreated cases.[17] Thus, a death during 1984 was considered to have an excellent probable outcome with medical treatment.

In other situations, a diagnostic group could be identified, but not a specific disorder. A child with acute lymphocytic leukemia presenting for medical attention in 1977 would have an expected 3-year survival of 74%[18] and 5-year survival >50%. Thus this child would be placed into the good outcome group. But a child with a nonspecified leukemia could only be assigned based on overall outcome for all types of the disease and was thus placed into the fair group.

In a few instances, judgment based on clinical experience had to be applied. For example, the data in all cases of renal failure were not adequate to determine an etiology for the end-stage disease. However, they were sufficient to exclude active processes such as Lupus or cancers. All of the teenagers in that group seemed to be good dialysis candidates, ensuring a >90% chance of long-term survival. Thus, the prognosis for their condition was considered excellent. In any situation in which the heterogeneity of clinical presentations made a simple, direct classification difficult, such as in the case of a foreign body aspiration, the most conservative classification that seemed reasonable was assigned.

Infants with fetal demise were placed in favorable prognostic groups only if adequate inspection or autopsy excluded major malformations. Although in utero demise can happen under obstetrical supervision, close monitoring improves detection and treatment of high-risk circumstances that lead to fetal loss. The expected outcome of a third trimester pregnancy is a live born, surviving infant, and thus, for the purpose of this review, expected outcome with care is excellent. Likewise, many of the preterm births might have been delayed with prenatal care or had successful neonatal supportive care. Thus, the expected outcome of preterm infants and stillborns was considered good.

Some of the infants studied were given the legal term stillborn on death certificates. In many cases, however, autopsy reports and witness statements indicated that death occurred during labor or delivery from causes that would have been easily prevented or treated with skilled assistance. Thus, for the purposes of this study, these perinatal deaths were listed in categories other than fetal demise.

TABLE 1. Classification of Expected Outcomes With Preventive or Remedial Medical Care

Classification	Criteria
Excellent	90% ≥expected survival
Good	50%–89% expected survival
Fair	10%–49% expected survival
Some benefit	<10% expected survival but expectation for pain and suffering reduction under medical care
No benefit	No significant improvement in outcome expected with medical care

RESULTS

Of 201 cases reviewed, 14 lacked sufficient information to be certain of the cause of death. In 15 cases, it could not be established that exclusive reliance on faith healing contributed to the demise. This left 172 children for evaluation.

Childhood Fatalities

The diagnoses of 113 children who died after their neonatal period are summarized in Table 2. Of the 98 children who did not have cancer, 92 would have had an excellent prognosis with commonly available medical and surgical care and 4 would have had a good outcome. Only 2 would not have clearly benefited from care. Many histories revealed that symptoms were obvious and prolonged. Parents were sufficiently concerned to seek outside assistance, asking for prayers and rituals from clergy, relatives, and other church members. For example, a 2-year-old child aspirated a bite of banana. Her parents frantically called other members of her religious circle for prayer during nearly an hour in which some signs of life were still present. In another case, a 6-week-old infant, weighing a pound less than at birth, died from pneumonia. The mother admitted giving the infant cardiopulmonary resuscitation several times during the 2 days before the infant's death. In one family 5 children died of pneumonia before the age of 20 months, 3 before the study period. Although this raises the possibility of genetic disorders such as cystic fibrosis, immune deficiency, or asthma, many such conditions have a good prognosis with treatment. Their mother was a nurse before joining a church with doctrinal objections to medical care.

One father had a medical degree and had completed a year of residency before joining a church opposed to medical care. After 4 days of fever, his 5-month-old son began having apneic episodes. The father told the coroner that with each spell he "rebuked the spirit of death" and the infant "perked right back up and started breathing." The infant died the next day from bacterial meningitis.

For the children with tumors, available medical care would have given them a reasonable chance for long-term survival and reduction of pain and suffering. A 2-year-old boy with Wilms' tumor had a primary that weighed 2.5 kg, approximately one sixth of his body mass. A 12-year-old girl was kept out of school for 7 months while the primary osteogenic sarcoma on her leg grew to a circumference of 41 inches and her parents relied solely on prayer. A timely diagnosis would have allowed at least a modest chance for survival.

Prenatal and Perinatal Fatalities

Table 3 lists the principal causes of 59 prenatal and perinatal deaths. All but 1 of the newborns would have had a good to excellent expected outcome with

TABLE 2. Child Fatalities Associated With Religion-motivated Medical Neglect

Diagnoses	N	Ages (Years Unless Specified)	Expected Outcome
General or miscellaneous:			
Cachexia, gastric aspiration	1	9	Excellent
Dehydration	6	4 mo, 5 mo, 1, 5, 8, 12	Excellent
Diabetes, type 1	12	3, 7, 10, 10, 11, 12, 12, 13, 13, 15, 15, 16	Excellent
Epilepsy, withheld medications	1	17	Excellent
Burns, 50% total burn surface area	1	1	Good
Hydrocephaly, myelomeningocoele	1	2 mo	Excellent
Foreign body aspiration	1	2	Good
Renal failure	3	15, 15, 15	Excellent
Trauma, motor vehicle accident	1	2	No benefit
Infections:			
Diphtheria	3	3, 4, 9	Excellent
Laryngotracheobronchitis	1	18 mo	Excellent
Measles (with complications)	7	1, 5, 9, 9, 13, 14, 16	Excellent
Meningitis, *H influenzae*	9	4 mo, 1 (7), 4	Excellent
Meningitis, *S pneumoniae*	4	2 mo, 5 mo, 1, 7	Excellent
Meningitis, bacterial, nonspecified	1	1	Excellent
Meningitis, posttraumatic	1	15	Excellent
Pericarditis, *S pneumoniae*	1	1	Excellent
Pertussis	1	1 mo	Excellent
Pneumonia (varying etiologies)	22	1 mo to 2 y	Excellent
Pneumonia/myocarditis	1	1	Good
Rocky Mountain spotted fever	1	4	Excellent
Toxic shock syndrome, staphylococcus	1	17	Excellent
Abdominal surgical disorders:			
Intussusception	3	8 mo, 9 mo, 14	Excellent
Appendicitis, ruptured	7	5 to 14	Excellent
Small bowel obstruction	1	6	Excellent
Strangulated hernia	1	6	Excellent
Volvulus	2	9 days, 26 mo	Excellent
Congenital heart lesions:			
Common atrioventricular canal	1	7 mo	Good
Double outlet right ventricle	1	12	No benefit
Ventricular septal defect, pneumonia	2	9 mo, 10 mo	Excellent
Tumors:			
Ewing's sarcoma	1	13	Good
Leukemia, acute lymphocytic	3	4, 5, 7	Good
Leukemia, nonspecified	1	2	Fair
Lymphoma, Burkitt's	1	13	Good
Lymphoma, non-Hodgkins	1	3	Good
Neuroblastoma	1	1	Fair
Osteogenic sarcoma	3	6, 12, 14	Fair
Posterior fossa, nonspecified	1	2	Fair
Rhabdomyosarcoma	2	4 and 5	Fair
Wilms' tumor	1	2	Good
Total	113		

medical care. The mothers generally declined prenatal care and the deliveries were either unassisted or attended by nonlicensed midwives. Two mothers had prior cesarean sections and had been advised against home delivery. Siblings of 2 deceased newborns had previously received court-ordered medical care for illness or injury. In one case, a relative of an infant with respiratory difficulty called for medical assistance, but a church elder turned the responding emergency crew away saying that with prayer the infant was breathing better. The infant died within a few hours. One infant was asphyxiated because of intrapulmonary bleeding, which might have been prevented with a routine vitamin K injection.

Pseudoscience was sometimes offered along with prayer. During 1 birth, a 3-day ordeal that included difficult labor and maternal convulsions, the founding elder of the sect told the mother her copious green vaginal discharge was "a good thing," a sign that she had peritonitis and poisons were being expelled thanks to the prayers of the group. It is likely that her discharge was meconium, a sign of fetal distress.

Deliveries attended by unlicensed midwives had tragic results. In one case, a 23-year-old woman presented to an emergency room after 56 hours of active labor with the infant's head at the vaginal opening for >16 hours. The dead fetus was delivered via emergency cesarean, and was in an advanced state of decomposition. The mother died within hours after delivery from sepsis because of the retained uterine contents. The medical examiner noted that the corpse of the infant was so foul smelling that it was inconceivable anyone attending the delivery could not have noticed.

Five additional mothers of perinatal infants died from complications of delivery. A few mothers eventually were treated in emergency departments for vaginal lacerations and retained placentas. In 2 cases, dead newborns had twin siblings who survived after being taken to hospitals.

Other Findings

A total of 23 denominations from 34 states were represented in this study. Five groups accounted for

TABLE 3. Perinatal Fatalities Associated With Religion-motivated Medical Neglect

Diagnoses	N	Comments	Expected Outcome
Fetal demise			
Preterm	3	26-, 32-, 34-week gestations	Good
Term	6	Large infants, some postterm	Excellent
Hydrops faetalis	1	Blood group incompatibility	Excellent
Preterm infants		(All over 30 weeks unless noted)	
Apnea, respiratory arrest	1		Excellent
Asphyxia	1	Nuchal cord, breech	Excellent
Intraventricular hemorrhage	1	34-week gestations	Good
Prematurity, severe	1	600 g, 1 month maternal bleeding	Good
Respiratory distress syndrome	5	30- to 34-week gestations	Excellent
Respiratory failure, unspecified	3	Several lived more than a day at home	Excellent
Septicemia, strep	1		Excellent
Traumatic delivery	1	Subarachnoid hemorrhage	Excellent
Term infants			
Anencephaly, myelomeningocoele	1		No benefit
Asphyxia			
nonspecified	5	Several failed unskilled resuscitations	Excellent
breech	6		Excellent
maternal shock	1		Excellent
nuchal cord	2		Excellent
prolonged labor	6	From 2 to 4 days	Excellent
uncleared secretions	2		Excellent
Birth trauma	5	Internal and external head injuries	Excellent
Hemorrhagic disease of newborn	1	Pulmonary hemorrhage, lived 4 days	Excellent
Hypothermia, shock	1		Excellent
Meconium aspiration	2		Excellent
Respiratory failure	3		Excellent
Total	59		

83% of the total fatalities (Table 4). Several states had totals disproportionate to population. There were 50 from Indiana, home of the Faith Assembly. Pennsylvania had 16 fatalities, including 14 from the Faith Tabernacle. The Church of the First Born accounted for the majority of 15 deaths in neighboring Oklahoma and Colorado. In South Dakota there were 5 deaths from the End Time Ministries. Nationwide, the Christian Science church had 28 deaths in the study.

Contacts with public agencies and mandated reporters of suspected child neglect were not unusual among the children. Believing they were powerless in the face of the parents' wishes, some teachers ignored obvious symptoms and sent lessons home to bedridden children. Some social workers and law enforcement officers allowed parents to decline examinations of children reported to be ill. Public officials did not investigate the deaths of some children.

One teenager asked teachers for help getting medical care for fainting spells, which she had been refused at home. She ran away from home, but law enforcement returned her to the custody of her father. She died 3 days later from a ruptured appendix.

A premature girl was delivered successfully at a hospital after her twin brother died during a home birth. Her mild respiratory distress syndrome resolved after 4 days of oxygen and other minimally invasive support. She then developed progressively severe apneic spells. The medical staff acquiesced to the parents' request not to transfer the child to a higher level unit, despite an expected good prognosis. She died 2 days later when she could not be resuscitated after a respiratory arrest.

TABLE 4. Religious Groups With Core Beliefs of Medical Care Avoidance

Organization Name	Deaths
Church of the First Born	23
End Time Ministries	12
Faith Assembly	64
Faith Tabernacle	16
First Church of Christ, Scientist (Christian Science)	28
Other denominations (N = 18), or unaffiliated	29
Total	172

DISCUSSION

Calculations of overall incidence and mortality rates are not possible in this study as the number of children in the groups sampled is not available and the cases were collected in a nonrigorous manner. However, we think that the comparison with outcomes expected in ordinary medical settings is a valid indicator that death and/or suffering were preventable in virtually all of these children. These fatalities were not from esoteric entities but ordinary ailments seen and treated routinely in community medical centers. Deaths from dehydration, appendicitis, labor complications, antibiotic-sensitive bacterial infections, vaccine-preventable disorders, or hemorrhagic disease of the newborn have a very low frequency in the United States.

We suspect that many more fatalities have occurred during the study period than the cases reported here. Deaths of children in faith-healing sects are often recorded as attributable to natural causes and the contribution of neglect minimized or not investigated. During the course of requesting documents for this study, we were told of deaths of children because of religion-motivated medical neglect that were not previously known to us from public records, newspapers, or other sources.

In many jurisdictions the classification of stillborn for an infant who has not taken a breath preempted

investigation of individuals involved in unattended deliveries, including unlicensed midwives.

The legal requirements for care of infants who have begun breathing are also inadequate in some states. One Indiana jury acquitted parents who let their 9-hour-old, preterm infant die without medical help. The judge instructed the jury that state law did not require the parents to obtain hospitalization until the infant had stopped breathing. Because survival after out-of-hospital cardiopulmonary arrest of infants is generally poor, such a law effectively obviates a duty to provide care.

In 1983, the federal government removed religious exemptions from federal mandate, allowing states to repeal them. The well-organized lobbying of exemption supporters, however, has defeated most repeal efforts. Today only five states, Massachusetts, Maryland, Nebraska, North Carolina, and Hawaii, have no exemptions either to civil abuse and neglect charges or criminal charges. The law and politics of this issue are discussed extensively elsewhere.[9,10,19–21]

Twenty-six percent of the deaths in this study have occurred since 1988, when the American Academy of Pediatrics first called for elimination of religious exemption laws[11] and several years after the federal government began allowing repeal. Excluding the Faith Assembly in which high reported maternal and child death rates declined after some prosecutions[22] and the death of its charismatic leader, 35% of the fatalities in this sample occurred from 1988 to 1995, 38% of the study period. Thus, it seems that this form of preventable child mortality continues unchecked.

From our observation, religious exemption laws promote the assumption that parents have the right to withhold necessary medical care from their children on religious grounds. Mandated reporters have been discouraged from contacting authorities or are unaware of their obligations and of means for state intervention. State agencies have sometimes hesitated to act on reports they do receive. Whereas Christian Science church leaders advise members in Britain and Canada to obey laws requiring medical care of sick children,[23,24] they have advised US members that the laws allow them to withhold medical care.[25,26] Several Pentecostal clergy and parents have also claimed that exemption laws confer the right to deny medical care to children.[27]

The American Academy of Pediatrics, American Medical Association, National District Attorneys Association, and National Committee for the Prevention of Child Abuse, among others, have adopted policy statements calling for the complete repeal of religious exemptions in child abuse and neglect and criminal statutes.[28–31] The children of members of faith-healing sects deserve the same protections under the law as other children have. We believe that the repeal of exemption laws is a necessary step toward assuring such protection and should be accomplished before hundreds more children suffer needlessly and die prematurely.

ACKNOWLEDGMENTS

We thank Drs Faith Kung and Alice L. Yu for their assistance in locating data on prognoses of tumor patients. Drs Lynne M. Bird, William B. Weil, and Donna A. Rosenberg made helpful suggestions on the manuscript.

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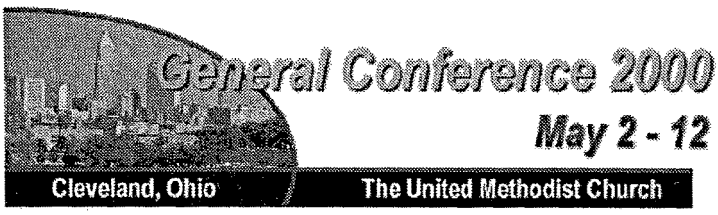

Whereas, the Federal Child Abuse Prevention and Treatment Act requires States participating in the grant program to include the failure to provide needed medical care in their definitions of child neglect; and

Whereas, the US Congress enacted the religious exemption to the requirement in 1996; and

Whereas, the religious exemption discriminates against a class of children, depriving them of protections to which other children are entitled; and

Whereas, many children have died or suffered permanent injury because their parents believed that the law allowed them to withhold medical care on religious grounds,

Therefore be it resolved that the United Methodist Church calls upon Congress to repeal Section 5106i of Title 42 of the United States Code, which states: "Nothing in this subchapter and subchapter III of this chapter shall be construed as establishing a Federal requirement that a parent or legal guardian provide a child any medical service or treatment against the religious beliefs of the parent or legal guardian. . . ."

Petition 31773-CS-NonDis-O adopted by the General Conference of the United Methodist Church on May 9, 2000. See gc2000.org/pets/PET/TEXT/p31773.asp

APPENDIX L – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY THE CONSORTIUM FOR CITIZENS WITH DISABILITIES TASK FORCE ON CHILD ABUSE AND NEGLECT.

Testimony for

The Committee on Education and the Workforce
Select Education Subcommittee
United State House of Representatives

Hearing on

Child Abuse Prevention and Treatment Act

August 2, 2001

Room 2175 Rayburn House Office Building

Submitted by:

Consortium for Citizens with Disabilities
Task Force on Child Abuse and Neglect

Contact: Jill Kagan, National Respite Coalition, 703-256-9578, ***jbkagan@aol.com*** *or Kim Musheno, American Association of University Affiliated Programs for Persons with Developmental Disabilities, 301-588-8252,* ***kmusheno@aauap.org***

The Consortium for Citizens with Disabilities (CCD) Task Force on Child Abuse and Neglect is pleased to submit written testimony on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) to the House Select Education Subcommittee of the Committee on Education and the Workforce.

CCD is a coalition of approximately 100 national disability organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

In 2001, the Consortium for Citizens with Disabilities made a significant and purposeful decision to establish a Task Force on Child Abuse and Neglect and to work in tandem with the National Child Abuse Coalition for one important goal – the prevention of child abuse and neglect. Children with disabilities are particularly vulnerable to child abuse, and child abuse may result in the acquisition or development of disabilities, which may, in turn, make children even more vulnerable for further abuse.

According to an HHS report released in April 2001, substantiated cases of child abuse and neglect investigated by child protective service (CPS) agencies numbered an estimated 826,000 children nationally in 1999. States report that nearly half (44.2%) of the child victims or their families in confirmed cases of child abuse and neglect receive no treatment or any other kind of services following investigation of the report. Deaths from child maltreatment remain unacceptably high: an estimated 1,100 children died of abuse or neglect in 1999 alone. And, as noted above, near-fatal child maltreatment leaves thousands of children permanently disabled each year.

Children with disabilities are, on average, 3.4 times more likely to be maltreated. Broken down by form of maltreatment, children with disabilities are 3.88 times more likely to experience emotional abuse, 3.79 times more likely to be physically abused, 3.76 times more likely to be victims of neglect, and 3.14 times more likely to be sexually assaulted than children without disabilities.

In addition to disabilities being a contributing factor to maltreatment, maltreatment can *cause* disabilities. The National Center on Child Abuse and Neglect (now, Office on Child Abuse and Neglect) determined that 36.6 percent of the substantiated cases of maltreatment in a 1993 study sample caused disabilities. Near-fatal child maltreatment leaves 18,000 children permanently disabled each year (United States Department of Health and Human Services, 1995).

In addition to the unconscionable human costs, the financial costs of the child maltreatment-disabilities dynamic are staggering. Approximately 22 percent of maltreated children have learning disorders requiring special education. According to a study by Health and Human Services, the future lost productivity of severely abused children is $658 million to $1.3 billion, if their impairments limit their potential earnings by only five to ten percent.

Such alarming statistics on the child maltreatment/disabilities nexus provide a cogent argument for attending to disability concerns in CAPTA. Toward that end, CCD's priorities for the current reauthorization of CAPTA are as follows:

- **Comprehensive health and developmental evaluations** – *Each child for whom there is an open case with Child Protective Services should be referred for a comprehensive health and developmental evaluation, if one has not already been done.*
- **Respite care services** – *Respite care should be more available, accessible, and affordable for families who are at risk of abuse and neglect, especially those families of children and/or parents with disabilities. Respite should be considered a core service of child abuse prevention programs.*
- **Equal protection for all children** –*All children should receive equal protection from abuse and neglect, including medical neglect, regardless of the health status, disabling condition, or any other characteristic of the child or child's parent(s)/caregiver(s).*

Rationale

Comprehensive Health and Developmental Evaluations: Chernoff et al. (1994) determined that over 90% of the foster care children in their study had an abnormality in at least one body system. While identification and treatment of the medical, developmental, and mental health problems of children have been shown to decrease the amount of time a child spends in out of home placements and increase the likelihood that he or she will experience stable living situations (Horwitz, Owens, and Simms, July 2000), numerous systemic and direct service barriers prevent many children in the child welfare system from receiving adequate health care (GAO, 1995). It is time for CAPTA to address this issue when a child is first referred to CPS for an investigation.

Respite: Research has demonstrated that respite is a successful, effective and cost-saving child abuse and neglect prevention strategy. One of the first comprehensive, comparative respite care studies of families with a disabled member found significant beneficial outcomes. This is especially noteworthy, given that children with disabilities are at much greater risk of abuse or neglect. The National Respite Coalition has summarized the effectiveness data for respite care in preventing child abuse and neglect, in enhancing family stability and lowering stress, and in reducing out-of- home placements. (See NRC testimony for the record).

However, respite is in short supply and the demand is great. During an average week, nearly 1,500 families representing 3,425 children are turned away from respite and crisis care programs because resources to meet the need are absent. In a 1998 survey of respite programs nationwide, half had families waiting for respite care at the time of the survey (ARCH National Resource Center on Respite and Crisis Care, 1999).

Recommendations

CCD believes that these priorities are essential in the prevention and treatment of *all* children, not just children with disabilities. In support of these legislative priorities, **CCD is requesting the inclusion of the legislative language in CAPTA being put forth by the National Child Abuse Coalition and lend our particular support to the following:**

- **Make Prevention a National Priority**. Preventing abuse and neglect of children from happening in the first place should be a national priority. Billions of dollars are spent on protecting and serving children once they are in the CPS and foster care system, while only minimal investments are made in up-front prevention. Redirecting CAPTA will keep

children safe and avert the long-term consequences and more costly out-of-home placements that result from serious abuse.

- **Comprehensive Health and Developmental Evaluations**: CAPTA will include discretionary funding for developing model programs in the provision of comprehensive health and developmental screenings. A required element of CPS intake protocol for selected pilot sites would be a determination of the child's health care coverage and an appropriate referral based on that determination.

- **Respite Services Should be Preserved as One of Core Community-Based Child Abuse and Neglect Prevention Strategies:** CAPTA should be the basic source of funding for proven effective community-based prevention programs, including the identified core programs of respite care, home visiting, parent mutual support, parent education, and family resource services.

- **Strengthen Role of Families of Children with Disabilities, Parents with Disabilities.** Recognizing that children with disabilities are at increased risk of abuse and neglect and that abuse is a significant cause of disabilities, CCD strongly supports all existing and NCAC proposed language in CAPTA Title II, which requires the involvement of families of children with disabilities, parents with disabilities, and agencies and organizations who work with families of children with disabilities to be an integral component of every aspect of program implementation and evaluation.

- **Increased Funding is Critical for Prevention.** Funding should be authorized at $500 million for Title II, which represents a modest commitment to support prevention of child abuse and neglect through CAPTA. It is also the amount necessary to begin to bring promising practices to scale and to keep local programs from having to turn families away from effective prevention services they are seeking voluntarily. CCD also supports an increase in Title I's authorization level to $500 million and to $100 million for research and demonstration.

- **Enhance Accountability.** CCD also supports the National Child Abuse Coalition's proposal to increase program and state accountability through improved reporting requirements to demonstrate effective and efficient use of funds under and in accordance with the Act.

In addition to requesting Chairman Hoekstra and his colleagues on the Select Education Subcommittee to include the above outlined language in CAPTA, **CCD also requests that Chairman Hoekstra and the other distinguished Subcommittee members encourage their colleagues on the House Appropriations Committee to increase funding for CAPTA to their full authorization levels for FY 02.**

Finally, CCD recommends that all children receive equal protection from abuse and neglect, including medical neglect. CCD's proposal is for CAPTA to include report language that precludes states from discriminatory practices in the provision of child abuse and neglect prevention and treatment services based on the health status, disability status, race, income, native language, ethnicity, religion, insurance coverage, gender, or any other characteristic of the child or the child's parent(s)/caregiver(s).

CCD has recognized that it is time for us to take a formal stand on preventing child abuse and neglect in the first place, and in protecting children from further harm once they enter the system, especially when children with disabilities are disproportionally represented. The evidence is now too great to ignore. We urge you to stand up as well and make child abuse and neglect prevention and treatment national policy priorities.

APPENDIX M – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY THE AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITES.

Testimony for

The Committee on Education and the Workforce
Select Education Subcommittee
United State House of Representatives

Hearing on

Child Abuse Prevention and Treatment Act

August 2, 2001

Room 2175 Rayburn House Office Building

Submitted by:
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The American Association of University Affiliated Programs for Persons with Developmental Disabilities (AAUAP) is pleased to submit written testimony on the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) to Chairman Hoekstra and the other distinguished members of the Select Education Subcommittee of the Committee on Education and the Workforce.

AAUAP is the national organization representing 61 University Centers for Excellence in Developmental Disabilities Education, Research, and Service, 36 Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Programs, and 20 Developmental Disabilities Research Centers. Collectively, these three types of programs perform an array of functions, such as academic preparation, community outreach and training, clinical and community services, research and evaluation, information dissemination, and advocacy. The purpose of these various functions is to help ensure that individuals with disabilities and their families live full, productive, satisfying, community-based, and self-determined lives.

For the programs represented by AAUAP, addressing the issue of child abuse and neglect is an integral part of both promoting the well-being of individuals with disabilities and their families, as well as preventing the development of disabilities. Indeed, cause and effect are intertwined when it comes to child maltreatment and disabilities. Children with disabilities are particularly vulnerable to child abuse, and child abuse may result in the acquisition or development of disabilities, which may, in turn, make children even more vulnerable for further abuse.

Children with disabilities are, on average, 3.4 times more likely to be maltreated. Broken down by form of maltreatment, children with disabilities are 3.88 times more likely to experience emotional abuse, 3.79 times more likely to be physically abused, 3.76 times more likely to be victims of neglect, and 3.14 times more likely to be sexually assaulted than children without disabilities.

In addition to disabilities being a contributing factor to maltreatment, maltreatment can *cause* disabilities. The National Center on Child Abuse and Neglect (now, Office on Child Abuse and Neglect) determined that 36.6 percent of the substantiated cases of maltreatment in a 1993 study sample caused disabilities. Near-fatal child maltreatment leaves 18,000 children permanently disabled each year (United States Department of Health and Human Services, 1995).

In addition to the unconscionable human costs, the financial costs of the child maltreatment-disabilities dynamic are staggering. Approximately 22 percent of maltreated children have learning disorders requiring special education. According to a study by Health and Human Services, the future lost productivity of severely abused children is $658 million to $1.3 billion, if their impairments limit their potential earnings by only five to ten percent.

Such alarming statistics on the child maltreatment/disabilities nexus provide a cogent argument for attending to disability concerns in CAPTA. Toward that end, AAUAP's priorities for the current reauthorization of CAPTA are as follows:

- **Comprehensive health and developmental evaluations** – *Each child for whom there is an open case with Child Protective Services should be referred for a comprehensive health and developmental evaluation, if one has not already been done.*

- **Respite care services** – *Respite care should be more available, accessible, and affordable for families who are at risk of abuse and neglect, especially those families of children and/or parents with disabilities. Respite should be considered a core service of child abuse prevention programs.*
- **Equal protection for all children** –*All children should receive equal protection from abuse and neglect, including medical neglect, regardless of the health status, disabling condition, or any other characteristic of the child or child's parent(s)/caregiver(s).*

AAUAP believes that these priorities are essential in the prevention and treatment of *all* children, not just children with disabilities. In support of these legislative priorities, **AAUAP is requesting the inclusion of the following language in CAPTA**:

- Title I
  - *National Clearinghouse for Information Relating to Child Abuse* – Direct the Clearinghouse to collect information, and develop and disseminate materials, that describe best practices being used throughout the nation for making appropriate referrals to, and addressing, the physical, developmental, and mental health needs of abused and neglected children through prompt comprehensive health and developmental evaluations.
  - *Research Activities* – Place a priority on the development of best practices in developing and maintaining linkages with local or community health care, mental health care, and developmental disability service providers that support prompt, comprehensive health evaluations for children who are the subjects of substantiated child maltreatment reports.
  - *Technical Assistance Activities* – Make technical assistance available to evaluate effective approaches being utilized to link child protective service agencies with health care, mental health care, and developmental services, including managed care programs, Medicaid providers, children's hospitals and other health care providers, and developmental disability programs (such as those that provide early intervention services), for forensic diagnosis and comprehensive health evaluations.
  - *Demonstration Programs and Projects* – Allow for grants to be awarded for the enhancement of linkages between child protective service agencies and health care services, including managed care programs, Medicaid providers, children's hospitals and other medical facilities, mental health providers, and developmental services (such as early intervention services), for forensic diagnosis and comprehensive health evaluations; and for innovative CPS/health provider partnerships that offer creative approaches to using existing federal, state, local, and private funding to meet the comprehensive health evaluation needs of children who have been the subjects of a substantiated case of child abuse and neglect.
  - *Innovative Programs* – Allow for grants to be awarded to entities that provide new linkages between state/local child protective services agencies and public health, mental health, and developmental disabilities agencies, where such linkages are designed to help assure that a greater number of substantiated victims of child maltreatment have their physical health, mental health, and developmental needs appropriately diagnosed and treated; and that demonstrate innovation in addressing the prevention of child abuse and neglect, the protection of children brought to the attention of child protective services, the treatment of abuse and neglected children, and the treatment for the victims of child abuse and neglect necessary to the recovery from the effects of that maltreatment, including community-based programs, national programs, and programs of collaborative partnerships among the State child protective services agency, statewide child abuse

prevention organizations, law enforcement agencies, substance abuse treatment services, health care services, domestic violence services, mental health services, developmental disability agencies, community social service agencies and family support programs, schools, faith-based organizations, and other community agencies.

- *Discretionary Grants* – Allow for the usage of grant awards for programs that provide potential model approaches for forensic diagnosis in suspected child abuse and neglect cases and for comprehensive health evaluations of children for whom a report of maltreatment has been substantiated, as well as projects that develop protocols for referring children for such screenings and diagnosis that draw upon best practices in linking such services.
- *Grants to States for Child Abuse and Neglect Prevention and Treatment Programs* – Allow grants that are made to States for improving their child protective services system to be used for the purpose of promoting partnerships between public agencies and private community-based programs to provide services and ensure the safety and well-being of children brought to the attention of the child protection system, including referrals to public health services to address the health needs of children identified as abused or neglected, and building linkages with education systems for attention to children in the child welfare system; and developing and maintaining linkages with local or community health care, mental health care, and developmental disability service providers that will support prompt, comprehensive health evaluations for children who are subjects of substantiated child maltreatment reports.
- *Grants to States for Programs Relating to the Investigation and Prosecution of Child Abuse and Neglect Cases* – Assist States in improving the handling of cases involving child victims of abuse or neglect with disabilities and/or serious health-related problems.
- *Definitions* – Insert a definition for "comprehensive health evaluation" that means a process equivalent to the Early and Periodic Screening, Diagnosis, and Treatment requirement, which should encompass, at a minimum, the child's gross motor skills, fine motor skills, cognition, speech and language function, self-help abilities, emotional well-being and overall mental health, oral health, coping skills, and behavior.

- Title II
  - *Authority* – Require grants to be made for the purpose of financing the start-up, maintenance, expansion, redesign, and networking of core community-based child abuse and neglect prevention programs, including respite, home visiting, parent mutual support, parent education, and family resource services that support the needs of families with children and parents with disabilities through respite care and other services, demonstrate a commitment to meaningful parent leadership (including among parents of children with disabilities and parents with disabilities), provide referrals to early and comprehensive health and developmental services that are accessible, effective, culturally responsive, developmentally appropriate, and strengths-based.
  - *Eligibility* – Lead entities must provide assurances that they will make available to local programs information regarding services that provide early and comprehensive health and developmental evaluations; will integrate its efforts with individuals and organizations experienced in working in partnership with families with children with disabilities and with the child abuse and neglect prevention programs and activities of the State, and demonstrate a financial commitment to those activities; and will award grants to core community-based child abuse and neglect prevention programs composed of local, collaborative, public-private partnerships directed by interdisciplinary structures with balanced representation from private and public sector members, parents, and public and

private nonprofit service providers, and individuals and organizations experienced in working in partnership with families with children and parents with disabilities.

- *Application* –Applications for Title II funds must contain a description of how the lead entity will provide or be responsible for providing developmentally appropriate services, supports and other assistance in a culturally responsive way that ensures that individuals from unserved and underserved populations in that State are fully included in all activities prescribed and allowed under this Title; and a description of outreach activities that the entity and the community-based, child abuse and neglect prevention programs will undertake to maximize the participation of racial and ethnic minorities, children and adults with disabilities, homeless families and those at risk of homelessness, and members of other underserved or underrepresented groups.
- *Lead Entities* – Require lead entities to demonstrate a commitment to meaningful parent leadership, including leadership among parents with disabilities and parents of children with disabilities, by specifying roles, functions and activities for these consumers in the development, operation, oversight and evaluation of the lead agency's policy making, grant making, and local operation of these community-based child abuse and neglect prevention programs.
- *Performance Measures* – States receiving grants must describe the number of families served, including families with children with disabilities and parents with disabilities, and the involvement of a diverse representation of families in the design, operation, and evaluation of core community-based, child abuse and neglect prevention programs.

In addition to requesting Chairman Hoekstra and his colleagues on the Select Education Subcommittee to include the above outlined language in CAPTA, **AAUAP also requests that Chairman Hoekstra and the other distinguished Subcommittee members encourage their colleagues on the House Appropriations Committee to increase funding for CAPTA.** Without such increases, the above listed and all other provisions in CAPTA will be stripped of their ability to make a meaningful difference in the lives of children and families.

Federal funding to help states and communities protect children and prevent child abuse and neglect has been woefully inadequate. Current appropriations for child abuse and neglect are only at half the authorized amounts. In fiscal 2001, basic state grants are funded at $21 million, discretionary grants at $33.7 million, and community-based grants at $32.8 million. These levels of funding demonstrate a complete disregard for prevention, when compared to billions of dollars spent on foster care and institutionalization at the far end of the child welfare services continuum.

As a result, hundreds of thousands of children remain in serious jeopardy and are even at risk of losing their lives. According to an HHS report released in April 2001, substantiated cases of child abuse and neglect investigated by child protective service (CPS) agencies numbered an estimated 826,000 children nationally in 1999. States report that nearly half (44.2%) of the child victims or their families in confirmed cases of child abuse and neglect receive no treatment or any other kind of services following investigation of the report. Deaths from child maltreatment remain unacceptably high: an estimated 1,100 children died of abuse or neglect in 1999 alone. And, as noted above, near-fatal child maltreatment leaves thousands of children permanently disabled each year.

Therefore, at a minimum, programs authorized under CAPTA in the FY '02 Labor, HHS and Education Appropriations bill should be funded at their fully authorized levels: $100 million for the basic state grants and the discretionary research and demonstration grants, and $66 million for the Title II community-based family resource and support program's prevention grants. To begin to close the gap between what federal, state and local dollars currently allocate to protect children and treat child victims, federal funding levels for the reauthorized CAPTA should be increased to $600 million for Title I and $500 million for Title II.

AAUAP urges Chairman Hoekstra and his colleagues on the Select Education Subcommittee to include the provisions outlined above and to fund CAPTA at a meaningful level. To not do so is to allow our nation's most vulnerable children to continue to be subjected to the most egregious violations of their human rights and to strap the American taxpayer with the ever-increasing price tag of responding to the devastating and far-reaching effects of child maltreatment.

APPENDIX N – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY DR. DAVID OLDS, DIRECTOR, PREVENTION RESEARCH CENTER FOR FAMILY AND CHILD HEALTH, UNIVERSITY OF COLORADO HEALTH SCIENCE CENTER.

Testimony for CAPTA Reauthorization

David Olds, Ph.D.
Professor of Pediatrics, Psychiatry, and Preventive Medicine
University of Colorado Health Sciences Center
Denver, Colorado

Thank you for the opportunity to offer written testimony on the Reauthorization of the Child Abuse Prevention and Treatment Act. I would like to use this opportunity to urge the committee to incorporate language into the bill to strengthen its emphasis on funding prevention and treatment programs that have met high evidentiary standards. As an example of such a program, I describe the Nurse-Family Partnership, a program that has been shown to reduce a wide range of adverse maternal, child, and family outcomes, including child abuse and neglect and childhood injuries. This program is widely considered to have the strongest evidence that child abuse and neglect can indeed be prevented. [1,2]

Program Model

In this program, nurse home visitors work with low-income women bearing babies in their homes during pregnancy and the first two years of the child's life to accomplish three goals:

- Improve pregnancy outcomes by helping women improve their health-related behaviors, including reducing use of cigarettes, alcohol, and illegal drugs;
- Improve child health and development by helping parents provide more responsible and competent care for their children; and
- Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Evidence of Program Effects:

Scientifically controlled studies of this program first in Elmira, New York, then in Memphis, Tennessee, and most recently in Denver, Colorado have found consistent benefits for low-income mothers and their children through the child's fourth year of life in:

- Improvements in women's prenatal health (e.g. reductions in hypertensive disorders and use of cigarettes)
- Reductions in children's health-care encounters for injuries
- Fewer unintended subsequent pregnancies and increases in the interval between first and second births
- Increases in women's employment and reductions in use of welfare and food stamps

In a 15-year follow-up of the Elmira sample, among low-income unmarried women and their children, the program also produced:

- 79% reduction in child abuse and neglect
- 44% reduction in maternal behavioral problems due to their use of alcohol and drugs,
- 69% fewer arrests among the mothers,
- 54% fewer arrests and 69% fewer convictions among the 15-year-old adolescents,
- 58% fewer sexual partners among the 15-year old adolescents,
- 28% fewer cigarettes smoked and 51% fewer days consuming alcohol among the 15-year old children,
- Four dollars saved for every dollar invested.

The Memphis and Denver studies were conducted more recently, so long-term follow-up data are not yet available in those sites. To date, the Memphis and Denver data confirm that the program has produced

statistically significant effects on its targeted outcome domains (women's prenatal health, infant health and development, maternal life-course) across all studies.
Independent evaluations of this research have consistently identified this program as a premier example of a program that has met the highest scientific standards of evidence. The program has been tested in a series of randomized controlled trials with different populations living in different contexts at different points in time. It has evidence of long-term impact and cost-savings to government. As a result of this strong evidentiary foundation, the program has received numerous awards (including the Charles A Dana Award for Pioneering Achievements in Health, ...) and has recently been cited by two recent reports by the Surgeon General – one emphasizing violence in our society and second focusing on mental health.

Replication Activities to Date
In 1996, at the invitation of the U.S. Department of Justice and a number of local communities, the National Center for Children, Families, and Communities at the University of Colorado has recently instituted the program in over 250 new communities across the country in 24 states, and has begun to serve more than 18,000 families in non-research settings. As this program is being scaled up, considerable attention is being given to developing organizational and community resources to ensure that it is conducted with fidelity to the model tested in order to ensure that the program continues to produce beneficial effects outside of research contexts. Costs of the program are usually funded through a variety of public sources, including welfare (TANF), Medicaid, the Maternal and Child Health Block grant, and child-abuse and crime-prevention dollars. The average annual program cost is $3,000 per family, with variation due primarily to nurses' salaries. We believe that, given the impact of the program on child abuse and neglect, a greater portion of funds for this program ought to be covered through CAPTA.

Proposed Modification of CAPTA Language
I urge you to consider modifying the 1996 provisions of CAPTA establishing Community-Based Family Resources and Support Grants to encourage states to allocate their funds to research-based programs. By that I mean programs that have been tested with randomized controlled trials, that the findings have been replicated with different populations living in different contexts, that the effects of the interventions endure, and that the results have been published in high-quality peer-reviewed journals. I recognize that this a high standard, but it is through this process that we can help ensure that programs of the highest quality are delivered to our most vulnerable families.

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APPENDIX O – SUBMITTED FOR THE RECORD, WRITTEN TESTIMONY BY THE AMERICAN ACADEMY OF PEDIATRICS.

American Academy of Pediatrics

Testimony of the

AMERICAN ACADEMY OF PEDIATRICS

submitted to the

Subcommittee on Select Education

Committee on Education and the Workforce

U.S. House of Representatives

for the hearing on

Reauthorization of the Child Abuse Prevention and Treatment Act

August 2, 2001

Submitted
August 9, 2001

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The American Academy of Pediatrics (AAP) is an organization of 55,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

Child maltreatment has always been of great concern to the Academy and its members, and we are committed to its prevention and treatment. As a member of the National Child Abuse Coalition (NCAC), we agree with the points made in the Coalition testimony. We would particularly like to emphasize and elaborate upon several issues.

Medical Neglect

As does the NCAC, the Academy strongly supports removal of Section 113, "Rule of Construction," from CAPTA. **This provision denies certain children the protection of the laws that apply to all others– namely, the laws requiring parents to provide necessary medical care for their children.**

Since 1983, CAPTA has required states to include medical neglect in their definitions of "child abuse and neglect." Yet, the Section 113 "Rule of Construction" – added to CAPTA in 1996 -- provides an exception to this requirement by permitting states to exclude religion-based medical neglect from their definitions of child neglect.

The second part of Section 113, which requires states to "have in place authority...to permit the child protective services system...to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, to provide medical care or treatment for a child," does NOT adequately protect children from their parents' failure to seek medical care on their behalf. The most prominent religions that oppose medical care reject *all* such care. Thus, the children of these religions' adherents are never brought to the attention of medical or child protective services personnel that could seek necessary court orders.[1]

Most states include religious exemptions in their state child neglect laws. If these exemptions were repealed -- so that all parents knew they had a legal obligation to obtain necessary medical care for their children -- many parents would obey the law, notwithstanding their religious beliefs. And, by getting simple medical care – such as life-saving insulin, antibiotics, or surgery – many children would be spared from needless death or suffering.[2]

The "Rule of Construction" in CAPTA is an obstacle to the repeal of state religious exemption laws, and thus, an obstacle to the provision of life-saving medical care for a select group of children. A disease or injury does not affect one child's body differently than another based on

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[1] This is in contrast to religions (e.g., Jehovah's Witnesses) that reject only blood transfusions. Hospitals routinely obtain court orders to provide transfusions to these children when necessary to do so.

[2] *See* AAP Policy Statement, "Religious Objections to Medical Care." *Pediatrics*, Vol. 99, No. 2, February 1997, pp 279-281, or http://www.app.org/policy/re9707.html.

the religious beliefs of the child's parents. In reality, failing to provide insulin to a diabetic child, for example, hurts the child – indeed, will likely result in the child's death – as much as other actions or inaction that our laws clearly prohibit, such as physical abuse or failure to provide food.[3]

That children have needlessly died due to religion-based medical neglect has been documented in a number of court cases (where the parents have been charged with manslaughter or sued for wrongful death)[4] and demonstrated in a study published in the American Academy of Pediatrics' journal, *Pediatrics* in 1998. In that study, a pediatrician who is an expert in child fatalities examined materials (e.g., trial, police, coroner records) related to the cases of 172 children who died in cases where their parents withheld medical care for religious reasons. In 140 of the 172 cases, the children died of conditions for which survival rates with medical care would have exceeded 90%. An additional 18 children would have had expected survival rates of more than 50%. All but three of the remaining children who died would likely have benefited from medical care. Pediatrics Vol. 101 No. 4 April 1998.

While religious *beliefs* should enjoy strong protection, *action or inaction* that hurts children is not protected by the First Amendment. This has long been the position of the Supreme Court, which held in 1944 that the Constitution's protection of religious freedom does not go so far as to give parents the right to harm their children. *Prince v. Massachusetts*, 321 US 158 (1944).[5]

Congress has no constitutional obligation to exempt parents with certain religious beliefs from the duty to provide medical care for their children. Congress *does* have a moral obligation to protect all children from medical neglect that results in needless death, disability, or suffering. Therefore, Section 113 of CAPTA should be repealed.

Health Evaluations

The Academy recommends that CAPTA be amended to encourage states to develop linkages with community health care, mental health care, and developmental disability service providers which will support prompt, comprehensive health evaluations for children who are the subjects of substantiated child maltreatment reports. As recommended by the NCAC, there are several places in the statute where references can be made to such linkages, including the sections on training programs, and activities that states may undertake with their basic state grant funds.

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[3] For example, it is clearly established that 90% of children with bacterial meningitis will die without antibiotic therapy; that children with insulin-dependent diabetes mellitus will die if insulin is not administered; and that the majority of children with peritonitis from perforated appendices will die without antibiotic therapy or surgery. These are examples of clear-cut situations where medical intervention makes the difference between life and death.

[4] *Lundman v. McKown*,

[5] "The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.... Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full legal discretion when they can make that choice for themselves." *Prince v. Massachusetts*, 321 U.S. 158 (1944), at 170.

Greater numbers of young children with complicated, serious physical health, mental health, or developmental problems are entering child protective services (CPS) systems during the early years when brain growth is most active. Children in foster care (and presumably, those who have suffered substantiated maltreatment but who are not in foster care) have disproportionately high rates of physical, developmental, and mental health problems, and often have many unmet medical and mental health care needs.[6]

It is critical to a child's long-term well-being to identify any developmental delays or disabilities that may have contributed to the causes of maltreatment, and to identify and treat the physical and psychological consequences of abuse or neglect. Ideally, each child for whom there is an open case with the CPS agency should receive a comprehensive health and developmental evaluation, and appropriate treatment.

Decisions about the child's placement, permanency planning, and medical, developmental, and mental health treatment plans should be informed by the social, medical, psychological, and developmental assessments of each child and the capabilities of the child's caregivers to meet those needs.

Prevention and Treatment

Numerous studies have demonstrated the high social and financial costs that Americans pay as a result of child maltreatment in terms of juvenile delinquency, criminal behavior, and health, mental health and substance abuse problems among its victims. The Academy agrees with the NCAC and other witnesses about the need for the federal government to put more resources into the prevention of child maltreatment so that less needs to be spent in addressing its outcomes for individual children and families, and for society as a whole.

Congress should provide much greater support for research and development of innovative programs to prevent and treat maltreatment; for primary prevention activities (e.g., home visitation) that will prevent maltreatment from occurring; for improvements to and support of the CPS infrastructure, so that vulnerable children are protected; and for evaluation and treatment of children and their families when abuse or neglect has occurred.

Accordingly, the Academy urges this subcommittee to authorize higher spending levels for CAPTA programs, as recommended by the NCAC ($500 million for the basic state grant program; $500 million for Title II community-based prevention programs; and $100 million for research and program innovations, training, technical assistance, data collection and information sharing).

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[6] *See* AAP Policy Statement, "Developmental Issues for Young Children in Foster Care." *Pediatrics*, Vol.105, No. 5, November 2000, pp1145-1150, or http://www.aap.org/policy/re0012.html.

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